SCHOOL LEADERSHIP AND SCHOOL MENTAL HEALTH:

AN EXPLORATORY STUDY OF SMH CONTENT IN

THE PREPARATION OF PRINCIPALS

by

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The increasing prevalence of K-12 students with mental health disorders is of great concern because research has shown that these children are at increased risk for academic failure. Accordingly, this study explored two intersecting fields of study – school mental health (SMH) and education administration, first examining the literature on the definition and prevalence of children's mental health disorders, the history of the SMH movement, and SMH competencies for school leaders.

What follows is an exploratory, multiple case study to determine the extent of SMH content within five nationally ranked U.S. principal preparation programs. A mixed methods analysis used text data derived from program mission statements, syllabi, faculty curriculum vitae documents and one program director interview. More than 94 documents were analyzed for SMH text evidence, resulting in 161 text units. These units then were coded by SMH dimension as well as by syllabi context (e.g., assignments, readings, and course objectives). Further inductive analysis revealed 14 SMH topics. Some text units reflected concepts that might be related to SMH (e.g., collaboration, community, and school culture). However, the terms "school mental health" and "children's mental health" never appeared in any documents, suggesting a lack of attention to the critical importance of children's mental health disorders and their contribution to poor school performance. Implications of the results as well as recommendations for improving national policy, state standards, local collaborations and higher

education preparation programs for school leaders are discussed. These recommendations include promoting better collaboration of national SMH and educational administration leaders in policy forums, incorporating student mental health as a priority in national guidelines for the preparation of school and district leaders, and rethinking preparation programs to improve the capacity of school leaders for developing and sustaining SMH partnerships.

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work together for over two decades has allowed me to move from an elementary school classroom into the world of policy and advocacy. It is my intention to carry on our work in support of children's mental health.

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1.0 INTRODUCTION

"In the long history of humankind (and animal kind, too) those who learned to collaborate and improvise most effectively have prevailed." ~Charles Darwin

Collaborations succeed when both parties benefit. For example, schools represent natural settings for collaboration and innovation to prevent, detect, and treat children's mental health disorders. Health care partners benefit from all-day access to children in need of care. Such availability decreases "no show" rates, increases efficiency, and thereby decreases cost to families, communities and the health care system (Paternite, 2005). Education partners, on the other hand, derive academic benefits when mental health barriers are removed and students are ready to learn (Binser & Försterling, 2002; Doyle et al., 2004; Fergusson & Woodward, 2002; Rothon et al., 2009). This symbiotic relationship has yielded a field called *school mental health*.

The implementation of school mental health is dependent upon many disciplines, including education. A key role is that of the educational leader. However, many school leaders, focused on academic instruction and assessment, are not prepared to assist children who are enduring internal struggles like never before (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007; Hootman et al., 2004). Every day, students live with mental health disorders such as traumatic grief, acute stress disorder, generalized anxiety disorder, separation anxiety, post

traumatic stress disorder, panic disorder, conduct disorder, depression, reactive attachment disorders and more. These disorders may surface as behaviors that often make learning difficult. In other words, a student in mental health distress is likely to be a student in academic distress (Binser & Försterling, 2002; Doyle et al., 2004; Fergusson & Woodward, 2002; Rothon et al., 2009).

Accordingly, this study explored the intersecting fields of study – school mental health (SMH) and education administration, first examining the literature on the definition and prevalence of children's mental health disorders, the history of the SMH movement, and SMH competencies for school leaders.

What follows is an exploratory, multiple case study to determine the extent of SMH content within five nationally ranked U.S. principal preparation programs. A mixed methods analysis used text data derived from program mission statements, syllabi, faculty curriculum vitae documents and one program director interview. More than 94 documents were analyzed for SMH text evidence, resulting in 161 text units. These units then were coded by SMH dimension as well as by syllabi context (e.g., assignments, readings, and course objectives). Further inductive analysis revealed 14 SMH topics. Some text units reflected concepts that might be related to SMH (e.g., collaboration, community, and school culture). However, the terms "school mental health" and "children's mental health" never appeared in any documents, suggesting a lack of attention to the critical importance of children's mental health disorders and their contribution to poor school performance. Implications of the results as well as recommendations for improving national policy, state standards, local collaborations and higher education preparation programs for school leaders are discussed. These recommendations

include promoting better collaboration of national SMH and educational administration leaders in policy forums, incorporating student mental health as a priority in national guidelines for the preparation of school and district leaders, and rethinking preparation programs to improve the capacity of school leaders for developing and sustaining SMH partnerships.

In the next chapter, the literature review explores the influence of children's mental health disorders on the school setting. Following a brief introduction to key terms in the school mental health field, the first section addresses the question, "How prevalent are children's mental health disorders in American public schools?" Determining how widespread mental health disorders are among school-aged children will help situate the urgency of school mental health and contributing disciplines.

The second section of the literature review chronicles the history of the school mental health movement in this country. An understanding of school mental health from its points of origin through current day practices is necessary to understanding overall expectations and competencies of contributing disciplines.

The final section portrays the involvement of educational leadership in the school mental health movement. School leadership is one of many collaborating disciplines of school mental health. This section reviews competencies expected of school leaders so that they can promote and prepare a context ready to couple with school mental health thereby building capacity and encouraging collaboration with other contributing disciplines.

2.0 LITERATURE REVIEW

2.1 DEFINITIONS

When considering both fields of school mental health and school leadership, there are a litany of terms, concepts, acronyms, and professional organizations, which may be new to the reader. Organized alphabetically, this section is meant to prepare the reader for such references throughout this dissertation.

Table 1. Definitions

Age of onset (AOO)	Medical term used to reference the mean age at which a disease or disorder may first be experienced.
Behavior Intervention Plan (BIP)	This plan is a document found in both education and clinical settings. A team that may include the student, teachers, school leaders, therapist, psychologists, and nurses develops the BIP. The goal of such a plan is to bring cohesion to the efforts of adults responding to targeted behaviors. These plans must include positive behavior interventions and be based on a Functional Behavioral Assessment (FBA).
Center for Mental Health Services (CMHS)	One of four centers located within the Substance Abuse Mental Health Services Administration (SAMHSA) "CMHS leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created CMHS to bring new hope to adults who have serious mental illnesses and to

	children with serious emotional disorders." (http://www.samhsa.gov/about/cmhs.aspx)
Community Mental Health Centers (CMHCs)	Mental health centers in the community where "mental health professionals were envisioned as consultants who would teach and train others to carry out therapeutic interventions, thereby extending their effectiveness" (L. Flaherty & Osher, 2003), p. 16).
Comprehensive school and system wide approaches	This refers to programs that address mental health needs of *all* students in the school/district. It includes a complete range of services from prevention to treatment.
Competency	A competency is a written statement that attempts to identify behaviors or situations that predict successful outcomes.
Continuum	Children with special needs warrant some level of service or treatment. The span of options ranging between less intensive, restrictive services to more intensive, restrictive services is known as the continuum. The word "continuum" may differ and can be used freely depending on its context, to refer to one of the following: range of services, placement options, or needs of the student.
Coordinated School Health (CSH)	Consisting of eight interrelated components, CSH (Allensworth & Kolbe, 1987) "is designed to promote health and mental health in schools by addressing the physical, social, emotional, and general needs for student well-being" (Hurwitz & Weston, 2010, p. 7).
Diagnostic and Statistical Manual of Mental Health Disorders, 4th edition, Text Revision (DSM-IV TR)	Issued in 1993, this reference manual organizes recognized psychiatric disorders and lists criteria for diagnosing each disorder (Stein et al., 2010). The DSM is organized and published by the American Psychiatric Association. The DSM-V is scheduled to be available in May of 2013.
Epidemiology	This is the study of diseases. In this paper, epidemiology refers specifically to the studies by epidemiologists of the causes and characteristics of children's mental health disorders as diagnosed by mental health professionals such as psychiatrists.
Expanded school mental health	In order to reduce the numbers of children in special education for emotional disabilities, the concept of *expanded school mental*

(ESMH)	*health* was created. ESMH provides a range of services for students in both general *and* special education (Flaherty, Weist, & Warner, 1996). ESMH resourcefully combines both school and community resources but services are provided in the school setting. (Weist, 1997a).
Free and appropriate education (FAPE)	§ 300.17 Free appropriate public education. "*Free appropriate public education* or *FAPE* means special education and related services that— (a) Are provided at public expense, under public supervision and direction, and without charge; (b) Meet the standards of the SEA, including the requirements of this part; (c) Include an appropriate preschool, elementary school, or secondary school education in the State involved; and (d) Are provided in conformity with an individualized education program (IEP) that meets the requirements of §§300.320 through 300.324." (Authority: 20 USC. 1401(9))
Full-service schools	Includes social services and primary health care that is, sometimes, but not always, on site in the school. These schools attempt to eliminate fragmented services – aspects may vary and can include ESL, adult classes, childcare, as well as health, mental health and social services.
Functional Behavioral Assessment (FBA)	An assessment that consists of data collection and analysis to determine the function of behavior(s). FBAs are mandated federal and state governments, but are not regulated. As such, there are many degrees of FBAs. Results of FBAs are used to develop behavioral intervention plans (Van Acker, Boreson, Gable, & Potterton, 2005).
Individuals with Disabilities Education Act (IDEA)	According to the National Dissemination Center for Children with Disabilities, "IDEA is our nation's special education law. The IDEA guides how states, school districts, and public agencies provide early intervention, special education and related services to more than 6.5 million eligible infants, toddlers, children and youth with disabilities" (Office of Special Education Programs, Department of Education, 2012)
Mental health	This term may reference the "field of mental health" or a person's overall mental health. In either case, this term refers to the overall state of "*both* mental health and mental illness"

	(Mental Health: A Report of the Surgeon General, p.3). This includes disease prevention, health promotion, surveillance of mental illness and access to services. Mental health is the "successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity; from early childhood until late life, mental health is the springboard of thinking and communication skills, learning, emotional growth, resilience, and self-esteem" (US Department of Health and Human Services, 1999).
Mental illness/Mental disorder	"…clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event, for example, the death of a loved one. Whatever its original cause, it must currently be considered a manifestation of a behavioral, psychological, or biological dysfunction in the individual. Neither deviant behavior (e.g. political, religious, or sexual) nor conflicts that are primarily between the individual and society are mental disorders unless the deviance or conflict is a symptom of a dysfunction in the individual…." (American Psychiatric Association & American Psychiatric Association. Task Force on DSM-IV, 1994), p. xxi).
Nosology	Nosology is the study of classifications of diseases.
Positive Behavioral Interventions and Supports (PBIS)	"PBIS is a framework or approach for assisting school personnel in adopting and organizing evidenced based behavioral interventions into an integrated continuum that enhances academic and social behavior outcomes for students" (Positive Behavioral Interventions and Supports, 2012).
Prevalence	The common occurrence of something. The frequency at which something occurs.

Response to Intervention (RtI)	"RTI is a multi-tiered approach to help struggling learners. Students' progress is closely monitored at each stage of intervention to determine the need for further research-based instruction and/or intervention in regular education, in special education, or both" (RTI Action Network, 2012).
School-based health centers (SBHCs)	SBHCs provide a range of physical and mental health services within schools (M. D. Weist, Goldstein, Morris, & Bryant, 2003).
School-based mental health (SBMH) or school-based behavioral health (SBBH)	Services and activities carried out on a school campus (H. Adelman & Taylor, 1999; L. Flaherty & Osher, 2003). These services may be owned by the school, the school district, or a community-based agency.
School based clinics (SBCs)	Clinics in schools that were prevalent in the 1980s and depending on monies, staffing could include nurses, physicians, substance abuse counselors, and social workers (Lear et al, 2003).
School-linked mental health centers	Services and activities carried on off-campus but with formal connection to a school (H. Adelman & Taylor, 1999; L. T. Flaherty et al., 1996). Generally this refers to a community owned services.
School mental health (SMH)	"policies, strategies, supports, and services along a full continuum of mental health promotion, prevention, and intervention efforts that are offered to all students in the school setting" (Hurwitz & Weston, 2010)
Specially designed instruction	As defined by IDEA §300.39, "Specially designed instruction means adapting, as appropriate to the needs of an eligible child under this part, the content, methodology, or delivery of instruction - (i) To address the unique needs of the child that result from the child's disability; and (ii) To ensure access of the child to the general education curriculum, so that the child can meet the educational standards within the jurisdiction of the public agency that apply to children (§300.39 (b) (3)).
Systems of Care (SOC) –	**"**A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health

	or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life" (Stroul & Blau, 2010, p. 61).
Text Units	Phrases identified when examining text in a document that fulfill the required search parameters.

In order to understand the field of school mental health, we must first examine mental health disorders in children – diagnosed and undiagnosed. To begin, the next section explains the frequency, or what mental health researchers refer to as *prevalence*, of mental health disorders[1] in youth who are of school age[2].

2.2 PREVALENCE OF MENTAL HEALTH DISORDERS IN SCHOOL-AGED CHILDREN AND ADOLESCENTS

[1] To be consistent with the terminology used in the school mental health field, this review primarily uses the term *mental health disorder* (as opposed to other terms such as *emotional disturbance* or *emotional and behavioral disorder*, more commonly used by educators.)
[2] This literature review does not encompass preschool children or post-secondary school-aged youth.

Before considering the data on children's mental health disorders, the reader should be aware of two factors that influence and complicate the reporting of such disorders and the interpretation of these reports. First, it must be noted that rates of mental health disorders (and associated high-risk behaviors) are commonly considered *conservative* estimates. This presumed underreporting is the result of the well-known stigma associated with seeking help for mental health disorders (Link, Yang, Phelan, & Collins, 2004). This is attributed to the discriminatory attitudes and beliefs held by the general public regarding mental health disorders. Contrary to the willingness to seeking help for physical health issues (such as colds, broken bones, or influenza), individuals either delay or fail to seek help when experiencing symptoms of poor mental health. In addition to the stigma associated with mental illness, this review of research considers prevalence data specific to school-aged children. Therefore, much of the research determining the age of onset of mental health disorders is dependent upon the recollection of subjects (Kessler et al., 2007). As such, we are reminded of the innate research limitations when utilizing retrospective reporting data.

Secondly, when determining whether a school-aged child has a mental health disorder, two different diagnostic systems are used in the US: the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV TR) and the eligibility criteria outlined under the Individuals with Disabilities Act (IDEA, 2004). This is a commonly accepted source of professional confusion (Zirkel, 2011). Because these two systems for determining whether a young person has a mental health disorder derive from disparate frameworks and authors, further clarification is in order. The DSM-IV TR, and previous editions of the DSM, derive from the American Psychiatric Association and therefore reflect the current nosology of psychiatry, a field of medicine. On the

other hand, the federal special education law (IDEA) relies on a single definition of emotional disorder that has evolved from its origins as a definition intended for a 1957 statewide mental health screening initiative in the state of California. When comparing the DSM-IV (utilized by mental health specialists and the field of psychiatry) and the federal special education law (utilized by systems of education) definitions and criteria are incongruent (Kavale & Forness, 1995; Bower, 1982; Kerr & Nelson, 2010). The double pathway in which children with emotional disorders are diagnosed under two systems based upon two varying diagnostic frames must be understood when considering prevalence data.

Given the disparities in the bases for determining eligibility of school-aged youth to receive services based on their mental health disorders, it is not surprising that the courts are populated with cases seeking settlement related to eligibility[3]. A leading special education legal expert recently examined the role of the DSM in US special education case law (Zirkel, 2011). His review showed that school districts commonly confirm IDEA eligibility by securing a DSM diagnosis. The courts generally held one of two positions: a) IDEA supersedes DSM, or, b) support for the use of both IDEA and DSM criteria. Rarely did courts grant the DSM more weight in eligibility decisions than IDEA. In other words, when disputes over eligibility and FAPE went to higher-level courts, the courts most frequently referenced disabilities, specifically emotional disorders, as defined in IDEA – not as they defined in the DSM. Yet, many educational psychological evaluations continue to reference the DSM for categories and criterion of emotional disabilities. Interestingly, for the few states that directly cross reference the DSM

[3] The term "eligible" comes from the special education system and refers to whether or not a child qualifies for special education services. A child may or may not be deemed eligible through a formal psychological evaluation.

to provide a definition of a disorder, the courts upheld the state code. This is as long as states add to the federal law and do not subtract from the federal law. Zirkel (2011) provides the example of the state of Illinois. Their state code cites the DSM definition of autism as their own definition for autism.

2.2.1 Major Reports on the Prevalence of Child and Adolescent Mental Health Disorders

The 2001 No Child Left Behind (NCLB) Act, a federal education law, and the 2003 report from the New Freedom Commission on Mental Health (a commission formed by Executive Order of then President Bush) spawned intensive research activity related to children's mental health. Both highlighted mental illness as a barrier to learning and called educators and researchers into action. The prevalence data cited in the NCLB regulations and in the Commission's report stems from three US federal departments: Department of Health and Human Services, Department of Education, and Department of Justice. These departments retrieve their data either through their own research or through the research of others. Each of these three US departments disseminates information on the prevalence of children's mental health disorders, as illustrated in Table 2. Table 2 lists several examples of significant government reports on children's mental health.

Table 2. Major Reports on the Prevalence of Mental Health Disorders in American Youth

Report	Date	Source

Mental Health: A Report of the Surgeon General	1999	US Departments of Health and Human Services, and its agencies: The Substance Abuse Mental Health Services Administration (SAMHSA), Community Mental Health Services (CMHS), National Institutes of Health (NIH), National Institute of Mental Health (NIMH)
Annual Report of School Safety	1999 -present	US Departments of Education and Justice
Report on the Surgeon General's Conference on Children's Mental Health: A National Action Agenda	2000	Departments of Health and Human Services, Education, and Justice. Foreword by Surgeon General, David Satcher. This agenda is an outgrowth of the *Surgeon General's Report on Mental Health*, 1999
Mental Health: Culture, Race, and Ethnicity, A Supplement to Mental Health: A Report of the Surgeon General	2001	US Department of Health and Human Services (DHHS)
School-Based Mental Health Services	2004	American Academy of Pediatrics, Committee on School Health
Mental Health, United States, 2008	2008	Substance Abuse and Mental Health Services Administration (SAMHSA)

Because the United States does not have a national registry of mental health disorders for children, most reporting bodies rely on reports of epidemiological evidence of children's mental health. One such report is a 12-month study investigating prevalence rates of mental health disorders as defined by the DSM-IV. Given the sample of over 3000 US children, "8.6% [met

the diagnostic criteria] for attention-deficit/hyperactivity disorder, 3.7% for mood disorders, 2.1% for conduct disorder, 0.7% for panic disorder or generalized anxiety disorder, and 0.1% for eating disorders" (Merikangas et al., 2010). Overall, one out of every eight children, ages 8 – 15 years, met the criteria for at least one of the six major DSM-IV disorders considered (Merikangas et al., 2010).

Another commonly cited source by government publications is a study conducted in 1996: NIMH Methodology for Epidemiology of Mental Disorders in Children and Adolescents. These data showed that 20.9% of children have one or more mental health disorders. Moreover, only 21% of those children received treatment for their disorders.

The US Department of Health and Human Services (DHHS) documents children's mental health disorders in the United States and releases the Surgeon General Reports. Thirteen years ago, the DHHS published a Surgeon General Report on the status of mental health in the United States (1999). This frequently referenced source estimated that 11% of children in the United States have at least one significant mental health disorder accompanied by impairment in home, school or peer contexts (US Department of Health and Human Services, 2001). The lower rate of prevalence reported in this study is likely due to their stricter criteria for inclusion (Forness, Kim & Walker, 2012).

In a slightly different report contributing to our understanding of the prevalence of mental health concerns in children, the Centers for Disease Control and Prevention (CDC) reported in 2006 that approximately 8.3 million children (14.5%) aged 4–17 years had parents who had communicated during the previous year with a health care provider or school staff member about their child's emotional or behavioral difficulties. (Simpson, Cohen, Pastor, & Reuben, 2008).

These parents' reports described 18% of all boys and 11% of all girls in the 4-17 age group, and were based on National Health Interview Survey (NHIS) data collected through personal household interviews conducted by the US Census Bureau.

Through its Committee on School Health, the leading professional organization for pediatricians, the American Academy of Pediatrics published a 2004 policy statement confirming the state of children's mental health. Between 1994 and 2004, the number of children in need of mental health treatment increased by over 12%. Using data from the Report on the Surgeon General's Conference on Children's Mental Health (2000), this policy statement highlighted prevalence data for children's mental health disorders as ranging from 17.6% to 22% (Costello, et al., 1996) in one study, and 16% in another (Roberts, Attkisson, & Rosenblatt, 1998).

Many of the aforementioned reports cited the research of Kessler (2007), and Kessler, Bergland, Demlar, Jin, Merikangas, and Walters (2005), which included data on what is known as "age of onset" (AOO), or the age at which symptoms first emerged. Recognizing and understanding the AOO of any illness - physical or mental - helps researchers, practitioners, and educators determine critical points of intervention and mitigation. Kessler et al. (2005) reviewed recent literature related to AOO, including survey research conducted by the World Health Organization. Despite the "dearth of information on AOO of mental disorders . . . presumably due to reluctance on the part of epidemiologists to rely on the retrospective reports obtained in general population surveys…" (p. 359), the authors concluded that mental health disorders may begin as early as age 7 (Kessler et al., 2005). Moreover, half of the adults who experience lifetime mental health disorders began to have symptoms in their mid-teens (Kessler et al., 2007;

Kessler et al., 2005).

Turning to the federal education agencies, one encounters different but related data that inform our understanding of children's mental health disorders. These reports derive directly from United States public schools. The US Department of Education's Office of Special Education Programs (OSEP) collects data from each state on the number of children with disabilities who require specialized services pursuant to eligibility for special education and related services. One of the 13 eligibility categories is "emotional disturbance," as defined in Table 3 below.

Table 3. C.F.R. §300.8 (2006). Child with disability[4]

(a) General. (1) Child with a disability means a child evaluated in accordance with §§ 300.304 through 300.311 as having mental retardation, a hearing impairment (including deafness), a speech or language impairment, a visual impairment (including blindness), *a serious emotional disturbance (referred to in this part as "emotional disturbance")*, an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services.

(2) (i) Subject to paragraph (a)(2)(ii) of this section, if it is determined, through an appropriate evaluation under §300.304 through §300.311, that *a child has one of the disabilities identified in*

[4] Italics added for emphasis to text addressing emotional disorders

paragraph (a)(1) of this section, but only needs a related service and not special education, the child is not a child with a disability under this part.

(ii) If, consistent with §300.39(a)(2), *the related service required by the child is considered special education rather than a related service under State standards, the child would be determined to be a child with a disability* under paragraph (a)(1) of this section.

(c) Definitions of disability terms. The terms used in this definition of a child with a disability are defined as follows: …

(4)(i) *Emotional disturbance means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance:*

(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.

(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.

(C) Inappropriate types of behavior or feelings under normal circumstances.

(D) A general pervasive mood of unhappiness or depression.

(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

(ii) Emotional disturbance includes schizophrenia. The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section.

Note that children who qualify under this category must have demonstrated difficulty with learning in order to be considered eligible for services, a caveat not present in the diagnostic criteria of the DSM. Note also that the definition makes no reference to the DSM. This perplexing disparity can be traced to the origins of the federal definition, a topic of continuing controversy in the field of children's mental health. The controversy warrants some attention here, because it provides context for interpreting the data reported under the current federal definition.

As astutely articulated by Forness and Kavale (2000), "Of several challenges that continue to face special education regarding children with emotional or behavioral disorders, the problem of eligibility is among the most pressing" (p. 267). As stated earlier, education does not reference the DSM – IV for criteria related to mental disorders. Rather, when determining if a student is eligible for educational support services under IDEA, in the category *emotionally disturbed*, teams of professionals align discussions with C.F.R. §300.8 (2006), provided in Table 3. While the majority of this 1975 federal definition (as explained earlier) was taken directly from a screening tool developed in the 1950s by Eli Bower,[5] one must note that section 4(ii)(E)

[5] Eli M. Bower (1917 – 1991) was a teacher and a psychologist. In 1957, along with his associates and funding from the State of California Bower developed, "a protocol for identifying California students who were in need of services because of their severe behavioral and emotional problems" (Merrell and Walker, 2004, p. 900).

of this code extends beyond the Bower definition of emotional disturbance. This section plainly excludes "children who are socially maladjusted, unless it is determined that they have an emotional disturbance under paragraph (c)(4)(i) of this section." Since the Code of Federal Regulations does not provide an operational definition for "socially maladjusted", this clause is interpreted subjectively thereby allowing for countless inconsistencies surrounding eligibility.

Merrell and Walker (2004) address this ongoing controversy regarding the definition and criteria for ED under special education law. They stress that by disqualifying children who are *socially maladjusted*, one is, in essence, eliminating parts of the very definition of *emotional disturbance.* Behaviors viewed by some as socially maladjusted are often behaviors indicative of emotional and behavioral disorders. For decades, there has been speculation in the field that this exclusionary clause was added in an effort to tame the numbers of children needing services for emotional and behavioral disorder. After all, contrary to the research demonstrating 20% of children have a mental health disorder, less than 1% of children in special education qualify for services in the category for emotional disturbance (Merrell & Walker, 2004). Reinforcing this point, the authors share research demonstrating that children who are diagnosed with Conduct Disorder, Oppositional Defiant Disorder, or Attention Deficit Hyperactivity Disorder are more likely to exhibit behaviors typical of social maladjustment. This is troubling because these antisocial behaviors are synonymous with the definition of emotional and behavioral disorders. The debate that continues in this arena revolves around either defining *social maladjustment* or eliminating it completely. Merrell and Walker (2004) suggest,

> Rather than looking for ways to exclude more students from receiving services, we should be investing our efforts in attempting to develop systems and solutions

that would allow more students to receive appropriate educational and support services because of their significant emotional and behavioral problems (p. 904).

After featuring several landmark reports on children's mental health as well as addressing the issues of definition and eligibility, this review of literature now turns to reports or prevalence directly from the Office of Special Education.

2.2.2 OSEP Reports of Children's Emotional Disorders (Emotional Disturbance)

Children evaluated and determined eligible under the Individuals with Disabilities Education Act (IDEA), a federal special education law, receive specialized services and instruction under categories such as Learning Disability, Developmental Disorder, Hearing Impairment, Intellectual Disability, etc. Of interest to this review is the category, "emotional disturbance."[6] Accordingly, the Office of Special Education Programs (OSEP) aggregates data from each state related to "emotional disturbance." The Office of Special Education Programs submits an annual report to the US Congress detailing the implementation of IDEA. The most recent *available* report was submitted in 2007 and was the 29th such report to date. Out of 65 million children educated in the US, 6 million (9.1%) received specialized services under IDEA. Of these 6 million children, 42,000 (.7%) children qualify for services under the category "emotional disturbance."[7] This means that these students receive specialized supports to address their

[6] The federal government does not mandate states to utilize the same names for disability categories. Hence, the use of disability categories varies by state. Other terms used by states include *emotional disability* (ED), or *emotional and behavioral disorders* (EBD).

[7] An astounding 51% of students in this category drop out of school (U.S. Department of Education, 2007).

emotional and behavioral barriers to learning. For children in the category of emotional disturbance, teachers perceive these barriers as internalizing and externalizing behaviors that are more than likely grounded in a mental illness. Supports for these behaviors can include a Behavior Intervention Plan (BIP), group or individual counseling, and other school mental health supports.

When evaluating children and youth for mental illness, clinicians also consider the frequency of what are known as *risk behaviors*. Exposure to certain situations or circumstances may increase the likelihood that a child will engage in risk behaviors. For example, approximately 25% of American children will experience some type of trauma before their sixteenth birthday (Costello, Erkanli, Fairbank, & Angold, 2002). This exposure to trauma increases the likelihood of risky behaviors and also places the child at risk for a mental health disorder. Risk behaviors are one of a few factors considered when diagnosing children and youth with a mental illness. Children and youth who engage in risk behaviors - using tobacco, alcohol or other drugs, engaging in sexual activity, or carrying weapons - are believed to be *at risk* for exhibiting, or likely to exhibit, signs of mental health disorders. Accordingly, the Centers for Disease Control monitor such behavior through a survey conducted every two years. One can view the results of the Youth Risk Behavior Survey (YRBS) for yet another perspective on how many American youth experience or are at risk for mental health disorders.

2.2.3 Reports of Risk Behaviors Commonly Associated with Youth Mental Health Disorders

The Youth Risk Behavior Survey (YRBS) coordinated and published by the Centers for Disease Control and Department of Health and Human Services (DHHS) is a survey of self-reported risk behaviors, some of which are associated with known mental health disorders. Children experiencing a decline in mental health may be more likely to engage in at-risk behavior leading to injury of themselves or others. The most recent YRBS, surveying over 16,000 youth, was completed in 2009. Results reflect the six areas for which youth, ages 10-24, were surveyed: 1) behaviors contributing to unintentional injury or violence; 2) tobacco use; 3) alcohol and other drugs; 4) sexual behaviors; 5) unhealthy dietary behaviors; and 6) physical inactivity. Table 4 provides a small sample of the 2009 data relevant to this review.

Table 4. 2009 Youth Risk Behavior Survey selected data

Behavior	Prevalence	Behavior	Prevalence
Carried a weapon	17.5%	Carried a gun	5.9%
Physical fighting	31.5%	Injured during a fight	3.8%
Dating violence	9.8%	Forced to have sexual intercourse	7.4%
Weapon on school property	5.6%	Physical fight on school property	11.1%

Bullied on school property	19.9%	Did not go to school for fear of safety	5%
Felt sad or hopeless (2 weeks in a row)	26%	Considered attempting suicide	13.8%
Made a suicide plan	10.9%	Attempted suicide	6.3%

The data in Table 4 deserve attention because these risk behaviors or self-reported feelings have a potential to lead to long-term mental illness, or even death. For example, 26% of youth who took the survey reported feeling sad or hopeless for more than two weeks, which, over time, can be one indicator of depression.

While the YRBS reports on behavior specific data, watchdog organization Annie E. Casey Foundation monitors situations that commonly place children at-risk for these behaviors and mental health disorders. This foundation collects, archives and analyzes situational data regarding factors such as homelessness, foster care, learning disabilities, poverty, unemployment, and single- parent households.

Another reporting avenue for children who are at risk is Title I, Part D, of NCLB, also called *The Prevention and Intervention Programs for Children and Youth who are Neglected, Delinquent or At-Risk.* Title 1, Part D assists state-operated educational programs for youth by providing financial assistance.

> The goals of Title I, Part D are to: (1) improve educational services for these children so they have the opportunity to meet challenging State academic content and achievement standards; (2) provide them with services to successfully transition from institutionalization to further schooling or

> employment; and (3) prevent at-risk youth from dropping out of school, and to provide dropouts and children and youth returning from correctional facilities with a support system to ensure their continued education.[8]

The office of Student Achievement and School Accountability Programs, under the federal Department of Education, Office of Elementary and Secondary Education (OESE) administers Title 1, Part D of NCLB. With an emphasis on decreasing youth with disabilities who enter the juvenile justice system, Title 1, Part D holds national and state specific data for children who are considered at-risk for criminal activity.

Reports associated with children's mental health disorders are not isolated. Rather, as reviewed in this section, there are multiple data sources that track behaviors and prevalence rates affiliated with mental health disorders nationally. One of the applications of such data involves the consideration of the cost of mental health services for children, and the cost of unmet mental health needs of children and youth.

2.2.4 Cost of Unmet Mental Health Needs

Critical to this section is the research that investigates the cost of *not* attending to mental health in schools. Failure to meet mental health needs of children and youth in schools is proven costly to society overall (Wade et al., 2008). Children and youth with mental health disorders are at increased risk for school dropout, criminal activity, substance abuse, unemployment or underemployment, as well as additional complicating comorbid mental health disorders

[8] Taken from http://www.neglected-delinquent.org/nd/aboutus/background.asp

(SAMHSA, 2004; SAMHSA, 2005). The effects extending from such are articulated in a report published in 2004 by the NIMH, *Preventing Child and Adolescent Mental Disorders: Research Roundtable on Economic Burden and Cost Effectiveness.* This report not only outlines difficulties of completing longitudinal cost analyses that encompass multiple systems, but it also discusses the burdens of unmet mental health needs on systems such as welfare, healthcare, justice, public safety and, of course, education. Recognizing that children whose mental health needs are met decrease the cost burden of systems as they grow older is important when considering the next section, History of the School Mental Health Movement.

2.2.5 Summary and Conclusions

This section responded to the question: How prevalent are children's mental health disorders in American public schools? Research tells us that 20% of children have a known mental health disorder. This review also revealed three complicating factors for the accounting of school-aged children's mental health disorders. First, schools typically qualify children as having an *emotional disturbance* via a federal definition has been the source of ongoing controversy and debate for the past 30 years. Second, mental health professionals and educators rely on completely different sets of criteria when qualifying children for mental health disorders. Mental health professionals utilize diagnostic criteria found in the DSM and educators refer to criteria located in IDEA. Lastly, the underreporting well acknowledged in the mental health field further confounds this definitional problem. In summary, roughly five students in each classroom of 25

probably are eligible under one set of definitions or the other to qualify for a mental health disorder.

Additionally, the resources designated to the three national data retrieval centers mentioned in this section – YRBS, Annie C. Casey Foundation, and Title 1, Part D of NCLB - are indicative of the national attention given to reducing mental health disorders in school-aged children. This can be viewed as a testament to the national level concern of negative outcomes affiliated with children's poor mental health. The allocation of monies in an attempt to define attributions of children's mental health, as well as promote evidence-based interventions, is significant to understanding the overall prominence of children's mental health.

As a response to the increasing mental health needs of school-aged children, a field of practice and research has grown out of community and school-based mental health services: *school mental health (SMH).* The roots and progression of school mental health are difficult to identify. This is because there appears to be no linear or direct pathway from the past to the present field of SMH. There are few absolute definitions and, in fact, general terms have been used interchangeably throughout decades. The lack of uniform nomenclature contributes to the puzzling genealogy of this field, which is the topic of the next section.

2.3 HISTORY OF THE SCHOOL MENTAL HEALTH MOVEMENT

School mental health is "policies, strategies, supports, and services along a full continuum of mental health promotion, prevention, and intervention efforts that are offered to all students in

the school setting" (Hurwitz and Weston, 2010). These supports enhance students' social, emotional and behavioral well-being. The alternative to school mental health, or what used to be called school-based mental health services, is community mental health services. The availability of school mental health services varies greatly between school districts across the United States. Some districts may refer families and children to community based services; some districts may contract with community mental health professionals who come into the school setting; and still others may have what is known as expanded school mental health (ESMH) programs. The school mental health movement endorses the later, full continuum of services available to all children – both general and special education (Weist et al., 2003). This is because research shows improved attention, increased academic performance, and increased engagement in academic activities result when a continuum of mental health services are available in the school setting (Bazelon Center for Mental Health Law, 2006).

Written evidence describing the field of mental health as a "movement" can be found over 35 years ago (Renner, 1975). The earliest written application of the word "movement" describing *school* mental health seems to be in 1997 (Weist, 1997b) within a chapter, *Expanded School Mental Health Services: A National Movement in Progress* in a the book, *Advances in Clinical Child Psychology, Vol. 19.* Since then, the school mental health movement has clear national leaders, organizations, journals, conferences, and agendas as described in this chapter.

Before chronicling the evolution of the school mental health movement, it is important to point out - as is often the case in other fields - that the evolution of mental health services in the United States reflects the combined impact of political, economic, and social forces over time. While the direct examination of how each of these forces contributed to mental health reform is

not the focus of this literature review, it is pertinent to recognize their influences. Authors such as Levine and Levine (1992) have written about the detailed influences of immigration, poverty, war, housing, rural and agricultural societies, communication, transportation, inventions, technology and other weights unique to each decade. Over time, "*Reform* describes the efforts of the socially conscious to achieve changes in the service of the less fortunate, or changes in the service of a different view of the social order" (Levine & Levine, 1992, p. 243). In other words, the history of mental health services is one that reflects the needs of children, as seen through the lens of the social and economic pressures prevalent during that time.

There are two additional threads of research that, while not explored in depth here, contribute significantly to our understanding of the history of school mental health. The first is the idea of accessing public schools to address public health issues. In reviewing the history of health services for children and youth, it becomes clear that basing social interventions in schools is a longstanding strategy. This strategy seems to convene a symbiotic relationship between those working to prevent or mitigate disease, illness, and injury, and those children and families seeking treatment. In sum, the school environment is a unique solution to multiple barriers (H. Adelman & Taylor, 1999; Lear, Gleicher, St. Germaine, & Porter, 1991).

The second area that this literature review acknowledges, but cannot fully explore, is the influence of numerous contributing professional disciplines. While the scope of this literature review is not to explore individual disciplines as they contribute to school mental health, it should be noted that each discipline has its own important history (Flaherty & Osher, 2003). Historically, professionals in nursing, psychology, psychiatry, school counseling, social work, and special education historically have integrated their approaches and collaborated in various

ways to address the mental health needs of children. In the following section, we see how the history of each discipline contributes to what we know today as school mental health.

2.3.1 Professional Disciplines Influencing the School Mental Health Movement

Many disciplines have contributed to the School Mental Health Movement (Hoge et al., 2007). In fact, experts in school mental health recognize that an interdisciplinary approach to the preparation of personnel for SMH is essential. Yet, complications surface when depending upon the collaboration of many disciplines - especially disciplines that span multiple fields. Describing it as a "workforce crisis" (Hoge, 2007, p. 1), The Annapolis Coalition on the Behavioral Health Workforce, as commissioned by the Substance Abuse Mental Health Services Administration (SAMHSA) in 2007, developed *An Action Plan for Behavioral Health Workforce Development: A Framework for Discussion.* This report surmises:

> …there are significant concerns about the capability of the workforce to provide quality care. The majority of the workforce is uninformed about and unengaged in health promotion and prevention activities. Too many in the workforce also lack familiarity with resilience- and recovery-oriented practices and are generally reluctant to engage children, youth, and adults, and their families, in collaborative relationships that involve shared decision-making about treatment options (p. 1).

Numerous expert panels contributed to this comprehensive report, which included seven strategic goals supported by objectives and implementation tables. Significant to this discussion of professional disciplines is the *Panel Report on School Mental Health Workforce Issues* (2006). Compiled by The Mental Health – Education Integration Consortium (MHEDIC), a 20-member national, multidisciplinary group, this report offers an overview and five recommendations addressing issues regarding school mental health workforce. Of great importance is the fifth and final recommendation – university-based training programs. Accrediting and training each contributing discipline in school mental health is critical to the integration of education and mental health. This report encourages the reexamination of higher education preparation programs as well as certification programs. Suggestions include: a) adjusting higher education curricula to include teaching mental health related disciplines the inner workings of a school, b) embedding "new curriculum options that address non-academic barriers to learning in classrooms and developing strategic school-family-community partnerships and integrated service delivery systems" (p. 28); and c) reviewing higher education curriculum with a goal of discovering exemplar programs with themes promoting interdisciplinary school mental health disciplines. Utilizing these exemplars, the MHEDIC panel suggests in their report the development of a certification program for *Advanced Interdisciplinary Mental Health Practice in Schools.*

Reinforcing the recommendation from the MHEDIC panel is Koller and Bertel (2006). These authors urgently call for a review of preparation programs, explicitly for school professionals. Koller and Bertel (2006) call for specific competency-based training for school professionals in the area of children's mental health. Citing warrants such as the inclusion of

children with emotional and behavior disorders into regular education classrooms, the prevalence of mental health disorders in school-aged children, the high numbers of children who go untreated, and the comorbidity of mental illness and dropout rates, these authors vigorously challenge the lack of curricular mental health training components in preservice training for school professionals.

In addition to understanding interdisciplinary efforts of the school mental health workforce, it is just as important to consider the origins of a few contributing professions: nursing, psychology, social work and counseling. Other disciplines not represented in this history window but equally significant to school mental health are psychiatry and special education.

Nursing. Concern for children in US schools, beyond their academic instruction, dates back to the late 1800s. In 1892, New York City addressed a public health concern - the spread of contagious disease - by initiating the first school health program. In 1902, the school health program actually employed a school nurse to assess ailments, provide treatment, and follow-up on recovery status (Lear et al., 1991). For many schools, nurses represented the first non-education discipline to be paid and integrated into the public school system. Throughout the 20th century, schools were increasingly staffed with school nurses until by 1980; there were over 45,000 nurses in what were considered *school-based health services* (Lear et al., 1991). Today, school nurses continue to play a viable role in school mental health. As part of an interdisciplinary team, school nurses recognize the integral role of both physical and mental health in regard to school achievement. In addition to helping children manage medications, the field of nursing prepares school nurses to screen and refer children for mental health services (J.

Hootman & DeSocio, 2004; Puskar & Bernardo, 2007). In fact, in a national survey of mental health services of over 83,000 schools[9] in the US, it was reported that nurses spend one third of their time addressing mental health needs of children.

Psychology. In 1915, the first official "school psychologist" position, intended for the entire state of Connecticut, was created (Fagan, 1987). The position, filled by Arnold Lucius Gesell, was for examining children who were thought to have a "mental disorder." With the institution of compulsory education in 1918, schools no longer taught only those fortunate enough to attend school. Specialized teachers were now needed to serve children who were slower learners or in poor general health. In order to discern students with such needs, the role of the school psychologist emerged as a kind of gatekeeper. The role of school psychologists has expanded exponentially, making "psychology" one of the major disciplines contributing to what we now know as school mental health.

Social Work. The decades from 1890-1930 are considered the Progressive Era. In addition to establishing nurses and psychologists, these decades also introduced the first social workers into the education system. Known as "visiting teachers," their curriculum efforts included vocational counseling, special education classes, and school clinics (Levine & Levine, 1992). The impact of these ideas were limited during this time because of realities such as wartime financial shortages, segregation, and the belief that education was only for reading, writing, and arithmetic. Nevertheless, the idea of addressing health concerns and social reform directly in the school setting was thought to be ideal (Levine & Levine, 1992). Organizational

[9] School Mental Health Services in the United States, 2002–2003 (U.S. DHHS, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006)

efforts of "visiting teachers" included clubs, classes, dramatics, athletics, crafts, dance, field trips, and food planning. Over time, the visiting teachers sought training in "casework, psychoanalysis, psychiatry, mental hygiene, and even mental testing" (Levine & Levine, 1992), p. 83). Combining social services with casework, the conception of the social worker narrowed the focus of "visiting teachers" to one of psychological and social problems of children.

Jane Day was the first visiting teacher hired by the Public Education System of New York in 1907. Six years later, The New York Board of Education hired a total of eight visiting teachers and quickly recognized the need for such services. Funds were secured for the specific purpose of establishing a visiting teacher service. Today, *school* social workers unite under the School Social Work Association of America and, as their predecessors did, continue to bridge education and mental health. Moreover, social workers take on major leadership roles in the school mental health movement as evidenced by the leadership of the Mental Health Education Integration Consortium (MHEDIC), chaired by Dawn Butcher-Anderson, professor of Social Work at Ohio State University. Leaders of MHEDIC, a national organization, work to endorse policy and encourage collaborative efforts between disciplines associated with school mental health.

Counseling. The original use of the term "counselor" began in the early 1900s and referred only to vocational counseling. In 1908, the first vocational guidance course was offered in a Detroit High School and was contrived by a school principal, Jesse Davis (Beale, 1986). In this same year, Frank Parsons who is known as the "father of guidance" founded Boston's Vocation Bureau (Beale, 1986). This Bureau was based in the community but provided vocational counseling to youth who were leaving school for employment. In 1939, this field

revealed one of its greatest contributions to communities as when the US Department of Labor published the first edition of the *Dictionary of Occupational Titles* (DOT) (Beale, 1986). By 1950, counselors were called "guidance counselors" in most school settings and regularly guided students using DOT as a common reference. As counselors have been integrated in the educational system, the field has grown through the inquiry of many issues. Questions asked include: a) "which students need the counselor the most" (Wrenn, 1962 p. 69)? b) "How should the artistic and mechanical students be served" (Wrenn, 1962 p. 69)? and c) How should "the physically and mentally handicapped children be served" (Wrenn, 1962, p. 71)? In 1952, The American School Counselor Association (ASCA) was formed.

Most school counselors, as they are called today, not only have a graduate degree but also have formal training in both mental health and education, making them ideal collaborators in school mental health initiatives. The American School Counselor Association (ASCA) provides national competencies for school counselors in three areas: academic development, career development and personal/social development (American School Counselor Association, 2004).

In sum, the literature reveals the entrance of many disciplines into the education system during the Progressive Era - late 1800s to 1930. A similar pattern of entry exhibited by several professions appears as follows: recognition of social needs of children → offer volunteer services to address needs → education system realizes positive effect → education system secures funding to hire more → field grows within the education system. With one leg in education and another leg in the general public, these disciplines have grown over the years adapting their skills and shifting their roles to serve the social and emotional needs of children and families in the school setting.

In addition to understanding the individual professions affiliated with school mental health, next this review addresses the dependency of the school mental health movement upon the collaborative efforts of these professions.

2.3.2 Collaboration of Professions within School Mental Health

Collaboration, as first mentioned in the introduction, is when two or more join forces knowing that their coupling will yield a greater outcome than efforts made alone. The literature holds a plethora of research related to the barriers and benefits of the collaboration process. Benefits of collaboration between professions working in school mental health can include: a) improved access to services; b) less disruption and fragmentation; c) increased information sharing; d) strengthen program sustainability; e) improved system relationships; f) and increased community ownership for its children (Gonsiulin, 2011).

For children with mental health disorders, successful intervention relies on the effective merging of systems (Leone, Quinn, & Osher, 2002). Examples of such systems include education, family and youth services, corrections, social work, drug and alcohol counseling, and other community based services. Collaboration between fields and professions passes through several stages before experiencing consistent success. The National Center for Mental Health and Juvenile Justice and others (Appelbaum, 2008; Babyak & Koorland, 2001; Darlington, Feeney, & Rixon, 2005) found that hindrances to successful collaboration include philosophical

barriers between systems, structural barriers between agencies, language and communication barriers, staff or stakeholder resistance, and funding issues.

School mental health relies upon the merging of education with multiple disciplines. As such, one can see how collaborative efforts are both critical and complicated. While the literature does not clearly place school mental health on any one stage of collaboration, this review later includes the current organization strategy for the Center for School Mental Health (CSMH), which is responsible for moving the field via policy and practice. The Center for School Mental Health has created 12 communities of practice all of which represent collaboration between multiple disciplines.

There are varying degrees of collaboration: between individuals, between small organizational groups, and between larger partnerships. A review of the literature confirms multiple models illustrating stages of collaboration (Gajda, 2004; Hogue, 1993; Peterson, 1991). Before arriving to the highest, most functional stage of collaboration, coadunation, it is thought that the merging organizations must first travel through lower stages. Frey, Lohmeier, Lee, Tollefson, and Johanning (2004) identified several models ranging from three to six stages of collaboration. While these authors map six stages (networking, cooperation, coordination, coalition, collaboration, and coadunation) given four different models (Gajda, 2004; Hogue, 1993; Peterson, 1991), they go one step further and recommend a lower level stage to present a seven-stage model of collaboration. On the lowest level as indicated in Table 5, the stage of coexistence is suggested to capture the mere existence of two organizations next to one another.

Table 5. Stages of Collaboration[10]

1. Coexistence	When each discipline operates in isolation of each other in their own silo. At this stage, trust and faith has yet to be developed.
2. Communication	There may be sharing about initiatives, but nothing concrete or even child specific. Rather, knowledge exchanged is only related to each other's capabilities.
3. Cooperation	Information sharing tends to be more specific and focuses on co training and cross training (Peterson, 1991; Hogue, 1993; Gajda, 2004).
4. Coordination	Work at this stage begins to complement each other. Examples include working together on common outcomes; perhaps the codevelopment of tools. Developed protocols are a bit more seamless (Peterson, 1991; Hogue, 1993; Gajda, 2004).
5. Coalition	Resources are on a common table and are no longer considered "my" resources and are viewed by all parties (Peterson, 1991; Hogue, 1993; Gajda, 2004).

[10] These seven stages encapsulate the models of Peterson (1991), Hogue (1993), Gajda (2004), and Frey et al. (2002).

6. True collaboration	At this stage there is truly no wrong door. Presenting problems requires no broker (Peterson, 1991; Hogue, 1993; Gajda, 2004).
7. Coadunation	This is a stage of unified organizational growth as one entity (Gajda, 2004; Frey et al., 2002).

Understanding the complexity of collaboration is essential to the review of school mental health as the field itself is greatly dependent upon merging multiple workforces in one setting: schools. As demonstrated in Table 5, the progression of such relationships encourages the understanding that the lack of collaboration is a barrier to school mental health. Collaboration to successful school mental health programming has been identified as a barrier to school mental health repeatedly (Adelman & Taylor, 2002; Burns et al., 2004; Clarke, Mazzuca, Krain, Power, & Eiraldi, 2005; Friesen et al., 2005; Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). Therefore, understanding the process and contexts of collaboration adds to our overall understanding of school mental health.

The role of policy goes beyond a consideration of disciplines within school mental health and its varying stages of collaboration. Other SMH goals addressed over time and cultivated through policy include; a) removing barriers such as funding; b) reducing repeated services between disciplines and settings; and c) maximizing the SMH capacity of schools.

2.3.3 Examples of Programs and Policy Promoting School Mental Health

Key to the evolution of school mental health is an understanding of historical public policy and the programs addressing the mental health of adults and children. The federal government currently promotes children's mental health through Departments of Health and Human Services, Welfare, Education, and Justice. Funds disseminated to individual states through initiatives and programs have increased significantly over the past twenty years. Early movement in the mental health field that led to increased funding was the Community Mental Health Revolution of the mid-1900s. It was during this time that mental health policy prevailed the early asylums of the 1900s. This section features Child Guidance Clinics as an example of early programs designed in response to mental health needs of children. It then landscapes three federal acts and four federal programs that epitomize government support for children's mental health.

Child Guidance Clinics. In 1899, the first Juvenile Court was established in Chicago as a public solution to an increase in juvenile offenders. Subsequent to the juvenile court system, was the Child Guidance Clinics (CGC) established during the 1920s. Child Guidance Clinics were an attempt to mitigate childhood delinquency and treat children in the community *prior* to institutionalization services. Staffing of such clinics consisted of a psychologist, psychiatrist, psychiatric nurse, and social workers. These clinics not only treated children, but also offered professional training to help "build up the mental hygiene capacities of other agencies" (Levine & Levine, 1992, p. 153). This included collaboration with local universities and the offering of elective courses in mental hygiene to high school juniors and seniors. An outgrowth initiative of the clinic was a prevention service in the form of a behavior clinic for kindergarten classes. The

clinic also initiated training for teachers featuring case presentations in an attempt to teach the "behavior of a child as symptomatic of some underlying cause" (Levine & Levine, 1992, p. 152). Child Guidance Clinics represent a significant piece of history for school mental health as it introduces the unidirectional movement of community based care interfacing with education. Like the Child Guidance Clinic that represented a movement to outpatient and preventative care, the Mental Health Study Act of 1955 was launched to define the state of mental health services in the United States as a first step towards eliminating institutional care and funding community based mental health services.

Mental Health Study Act of 1955. In 1955, the federal government first responded to concern about people's mental health. The Mental Health Study Act paved the way for further policy related to mental health, including children's mental health. In response to a campaign by the American Psychiatric Association, the American Medical Association, the national Institute of Mental Health (newly formed in 1955), and the National Committee Against Mental Illness, the Mental Health Study Act of 1955 authorized a comprehensive review of the American mental health system. Congress assigned the responsibility of conducting the study to the Joint Commission on Mental Illness and Health. In 1960, the Joint Commission finally issued a summary entitled, *Action for Mental Health*. Divided into three sections - Pursuit of New Knowledge, Better Use of Present Knowledge and Experience, and Costs - this report delivered a blueprint of a revised public mental health system substituting community mental health care for state institutional care. Among other very important discoveries and proposals, the commission recommended one mental health outpatient care unit to every 50,000 persons, called for states to *triple* their spending on mental health systems over the 10 years to follow, and proposed

expanding the role of NIMH (Rochefort, 1993). As a result of the Mental Health Study of 1955, the development of the Community Mental Health Centers Act began in 1960.

Community Mental Health Centers Act of 1963. Implemented by the Kennedy Administration, the development of this act was based in part on testaments of the high number of people who were mentally ill. Individuals also" a) testified about the decaying and harmful conditions in state hospitals; b) clarified comparisons between physical and mental health; and c) finally featured community mental health as the preferred treatment over isolation in state hospitals (Rochefort, 1993). In its final state, the 1963 Community Mental Health Centers Act emphasized the number of mentally ill persons, the costs of custodial hospitals, new therapeutic techniques for treatment, and the importance of prevention. According to Lear et al., (1991), the population of 15-24 year-olds surged between 1960 and 1980 by 77% - from 24 million to 42.5 million. Subsequently, the education system in the 1960s and early 1970s experienced a plethora of mental health concerns because the children of Baby Boomers had reached middle and high school age (Lear et al., 1991). Therefore, the timing of this act was profound for laying a foundation for the School Mental Health Movement.

As a response during the 1970s, the country experienced attempts to create more comprehensive health clinics. Yet, it was not until 1987 that the number of school-based health clinics (SBCs) exceeded 150 and were located in middle and high schools across the country (Dryfoos, 1988). The initial purpose of SBCs was not mental health, but primarily medical: immunizations, vision and hearing screenings. However, SBC's more commonly offered supplemental mental health services in order to address teenage pregnancy and sexually

transmitted diseases. This was typically achieved by partnering with outside clinics (L. T. Flaherty et al., 1996).

The Center for Population Options reported that by 1993, there were 500 SBCs throughout 32 states (Flaherty et al., 1996). The success of SBCs, as evidenced by a decrease in teenage pregnancies, gained the attention of organizations such as the American Academy of Pediatrics. As such, the US Public Health Service's Healthy People 2000 program, through its Office of Technology Assistance (OTA) 1991 report recommended expansion of SBCs (Flaherty et al., 1996). In the years to follow, both the Bush and Clinton administrations endorsed this recommendation (Flaherty et al., 1996). In addition to the outgrowth of mental health services through SBCs, another stimulus for such school-based mental health services was Public Law 94-142, the federal special education law.

The Education for All Handicapped Children Act - Public Law 94-142, 20 USC. 1400 et.seq. In 1975, this law became the federal government's response to the millions of children with limited or no access to education because of perceived disabilities. Public Law 94-142 mandated schools to provide a free and appropriate education (FAPE) to *all* children with disabilities. This meant that the provision of many services for children with emotional disorders was then the responsibility of public schools. In other words, mental illness was viewed as a barrier to learning. Children in public schools struggling academically due to mental disorders were entitled to services that would mitigate their emotional disturbance and improve their academic performance. PL 94-142 was amended in 1980, 1986, 1990, 1997, and 2004. It is currently called the Individuals with Disabilities Education Improvement Act (IDEIA). Amendments over the years include changes to funding formulas, eligibility determination, Least

Restrictive Environment (LRE), discipline procedures, early intervention, and transition planning.

Child and Adolescent Service System Program (CASSP) 1983. As mandated and funded by the federal government, the National Institute of Mental Health (NIMH) instituted the Child and Adolescent Service System Program (CASSP). The Child and Adolescent Service System Program addressed the complicated planning needs for families involved in several systems including child welfare, education, and juvenile justice. This program is an example of efforts to improve systems of care for children and youth in need of mental health services.

Systems of Care (SOC) 1986. SOC was first defined as a philosophy and framework to blend and braid branches of services for families in need of support. Developed in the 1980s, the SOC framework was designed to decrease the high number of children with serious emotional disturbance who were removed from their communities for treatment. Located in or near the child's home and community, SOC integrates both public and private human resources and services in a collaborative effort to meet the mental health needs of the child and family. Systems of Care was developed as a framework to help provide a conceptual way of thinking about service delivery. This common framework makes building an infrastructure that supports and sustains the contributing workforce less complicated. SOC emphasizes community-based, family-driven, youth-guided, and cultural and linguistic competence**.** In other words, SOC enables the family to decide upon what services they think they need (Kilmer, Cook, & Palamaro Munsell, 2010). The eight components of SOC are: mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services, and juvenile justice services (Stroul & Blau, 2010).

Comprehensive Community Mental Health Services for Children and Their Families Program 1992. The Comprehensive Community Mental Health Services for Children and Their Families Program is the major national source of funding for SOC programs. Congress passed legislation creating the Comprehensive Community Mental Health Services for Children and Their Families Program, in order to promote community collaboration through the systems of care philosophy. This program continues to create cooperative agreements with states and communities in order to disseminate funding for such programs. Over the past twenty-six years the conception of the SOC philosophy, has infiltrated into 23 states and receives a total of 14 million dollars to expand their SOC services[11]. This could be viewed as proof of the government's commitment to decrease barriers to mental health services for children and their families.

Safe Schools, Healthy Students (SS/HS) 1999. A final example of federal government program promoting children's mental health is Safe School, Healthy Students. The SS/HS Program has played a major role in the recent movement of school mental health. Supported by three, collaborating, federal agencies-the US Departments of Education, Health and Human Services, and Justice –SS/HS is a grant-funded program established in 1999. With an overarching goal of promoting safe, disciplined, and drug free school environments and healthy child development, SS/HS channels federal funding to communities and schools that work together to implement comprehensive programs which address all five of the following elements: safe school environments and violence prevention activities; alcohol and other drug prevention

[11] http://www.samhsa.gov/newsroom/advisories/1109223920.aspx retrieved December 2011.

activities; student behavioral, social, and emotional supports; mental health services; and early childhood social and emotional learning programs.

To summarize, federal level recognition and provision for the needs of children with mental health disorders, as evidenced by the sample of policy and sustainable programs cultivating mental health, is significant. Without the ability of the citizens to move research from policy to practice, the movement of school mental health would be stale. However, policy and legislation alone are not adequate to revolutionize a system. Next, we will consider literature that reveals how experts question and implement practice indicative of growth and movement in the field of school mental health.

2.3.4 Indicators of Movement in School Mental Health

The literature provides evidence of advancement within the field of school mental health. However, a review of the steadfast development in this field is subsequent to understanding *why* it is critical to address mental health in schools. Over the past 20 years, the accumulation of research surrounding school mental health has transpired only because research has tied academic achievement to mental health. In 1993, Achenbach and Howell published their longitudinal study spanning 13 years. Ten percent of children qualified for clinical treatment in 1976 as compared to 18.2% of children studied in 1989 – an increase of 8.2%. This landmark study ignited research investigating the concomitance of academic achievement with school variables related to mental health such as school dropout rates, aggressive behaviors, substance

abuse, retention and attendance. In 2004, two similar studies linking academic achievement and mental health confirmed significant results (Benner, Nelson, Lane, & Smith, 2004; Reid, Trout, Epstein, Nordness, & Gonzalez, 2004). As such, mental health disorders are viewed as a proven barrier to learning. Couple this research with research that suggests students are more likely to seek help when mental health services are available in school (Slade, 2002; Slade, 2003; Weist & Evans, 2005) and the field of school mental health is quickly advancing.

The section reveals significant growth in school mental health within the past 20 years (Weist & Paternite, 2006). Catapulting this growth, among others, are three clearly defined concepts from leading experts in the field. The first is a set of nine barriers to school mental health. Utilizing action research to delineate obstacles to advancement of school mental health, these barriers have served as a platform for current and future researchers who strive to create or discover solutions to such barriers. The second indicator of growth is a set of principles developed for expanded school mental health (ESMH). These ten principles serve as a guide to many disciplines collaborating to build capacity of their school mental health programs. The third indicator of the growing school mental health field is the number of professional organizations and assemblies mobilized in support of moving research to policy and then practice.

2.3.4.1 Barriers to School Mental Health

Helping to move the field of school mental health is the analysis of practice and application of research to clearly define specific barriers. A review of the literature shows that the research examining barriers to school mental health fall into one of two categories. The first includes

research that uncovers mental health barriers to learning. While this is a main premise for school mental health, it is not included in this section, which focuses on barriers to successful programming of school mental health. Rather, the focus here lies with the second set of research highlighting barriers to the implementation of school mental health itself. These barriers are important to the intersection of school mental health and educational administration.

Co-author of *Building An Interconnected Policy-Training-Practice-Research Agenda To Advance School Mental Health* (2006), Mark Weist is the former director of the Center for School Mental Health, a policy and analysis center that aims to promote the expansion and improvement of mental health programs in schools across the country. Together with Carl Paternite, the authors, with a goal of embedding mental health services for children in schools, developed a solid platform from which to spur policy and practice. Applying their own research as well as others, they outlined nine immediate "challenges to the advancement of school mental health" (Weist & Paternite, 2006, p. 175).

Weist and Paternite (2006) assert that unless these challenges are further researched and overcome, the effective integration of education and mental health to create school mental health will fail to thrive. They explain:

1. Poor understanding of mental/behavioral health of children by school leaders only perpetuates the perception of mental health as an added service – an issue only addressed when a student is in serious distress. Historically, school reform encompasses cognitive related efforts that are central to the academic mission of schools and avoid non-cognitive barriers (e.g., depression, negative peer and family influence, nutrition, and exposure to

trauma and violence). Furthermore, entrenching this notion, NCLB failed to assess for social, emotional, or behavioral conditions of education.

2. The variability of mental health delivery systems between states and communities is a challenge. The authors argue the "implications of federalism for child-serving systems and related school decision making realities" (Weist & Paternite, 2006, p. 177) create substantially high rates of all too fluid policy and organization. This variance between communities and schools creates a platform that proves unstable to support the integration of mental health and schools.
3. The authors call for mental health professionals to make a strong case interrelating academic and mental/behavioral health needs of children. In order to address intricate funding issues, school leaders will need to work with mental health professionals to not only locate underutilized funds but also advocate for appropriate funding to transform the current system of "over-burdened school-employed mental health professionals".
4. With current school based mental health programs, there is an abundance of referrals. The challenge here is a service-delivery capacity problem. Perpetuated by the lack of funding and marginalization, the integration of these two systems will need to be ready to sustain services for direct referrals while still promoting school-wide preventative measures. Weist and Paternite (2006) posit that the reluctance of schools to integrate with mental health services contributes to this problem.
5. The authors cite research that surveyed teachers and their role in promoting student mental health. Seventy percent of respondents did not receive courses in college addressing mental

health needs of children. While school psychologists and social workers are the leaders for this area, training and role definition for educators is critical.

6. Currently, the licensing, credentialing, and certification of psychologists and social workers is divided into school *or* community practice. These boundaries have become blurred as schools and community agencies hire regardless of certificated area.
7. The authors urge for school and mental health professionals to avoid the current practice of child community mental health for which family participation is limited. Serious considerations and remedies must be ready to maximize parental participation, which research clearly suggests will increase the effectiveness of treatment.
8. Confidentiality and privacy laws will prove to be a monumental challenge as HIPAA and FERPA meet in the context of school mental health. This will include training teachers, keeping accurate records and designing appropriate spaces. Further, there is a need to develop "well-articulated standards for more flexible and contextually driven intervention and prevention services" for the purposes of determining what services "billable" and "non-billable" (Weist & Paternite, 2006, p. 183).
9. Finally, the authors argue for a merged infrastructure that will provide a full continuum of mental health practices in schools avoiding ineffective and fragmented approaches. Realistically, this must include family-educator-mental health collaboration as well as joint professional training to delineate the roles, definitions, and services.

The joint efforts of the Weist and Paternite (2006) have yielded a powerful guide from which researchers and professionals have already begun to move forward. Following this 2006 publication, the literature encompassing school mental health clearly begins to research and

address these nine barriers. For example, in a 2007 article titled, *Transformation of Children's Mental Health Services: The Role of School Mental Health*, the authors present strategic points for school mental health workers to consider. These strategies directly address some of the barriers defined by Weist and Paternite (2006). They are: demonstrate relevance to schools, develop consensus among stakeholders, enhance community mental health- school connections, build quality assessment and improvement, and consider the organizational context of schools (Stephan et al., 2007).

Another study completed in 2010 by Langley, Nadeem, Kataoka, Stein and Jaycox used semi-structured interviews of clinicians who implemented Cognitive Behavior Intervention For Trauma In Schools (CBITS) to reveal barriers to successful implementation. The top four responses were lack of parent engagement, competing responsibilities, logistical barriers, and lack of support from school administrators and teachers.

Representing *teachers'* perceptions of barriers to school mental health is a recent 2011 study from the University of Missouri (Stormont, Goel, Herman, Reinke, & Puri, 2011). Surveying close to 300 elementary school teachers, 89% agreed that schools should address the mental health needs of children; however only 34% felt prepared to carry out their role to provide such support. Interestingly, this study revealed that 44.5% of teachers surveyed did not know what "evidence-based" meant. Presented with a list of barriers, the top four barriers to service were a) inadequate parent support programs, b) lack of prevention programs for students with externalizing behaviors; c) lack of prevention programs for students with internalizing behaviors; and d) ineffective or nonexistent staff training and coaching. Further, when asked open-ended questions seeking *opinions* of barriers to school mental health support, the analysis

revealed, “insufficient numbers of school mental health professionals, lack of training for dealing with children’s mental health needs, lack of funding for school-based mental health, and stigma associated with receiving mental health services” (Stormont et al., 2011, p. 8).

Just as the literature shows that defining barriers generates movement in the field of school mental health, so does an establishing principle. Principles can provide collaborating disciplines with common goals. Such is the case with the ten principles created to fuel efforts toward expanded school mental health (ESMH).

2.3.4.2 Ten Principles of School Mental Health

The Center for School Mental Health (CSMH) created a set of 10 principles for best practice based on a qualitative research process funded by the National Institute for Mental Health (Lever et al., 2006). The ten principles are based on best practice and are considered examples of a “well-established school mental health program” (Lever et al., 2006, p. 1011). The premise of these principles was to continue the momentum of the expanded school mental health (ESMH) and efforts related to providing a full continuum of mental health services within schools. Expanded school mental health is the expansion and augmentation of mental health services already located in schools (Lever et al., 2006). Characteristic of ESMH is the emphasis given to preventative care, as well as access to mental health care regardless of a family’s ability to pay for care.

Table 6. Ten Principles for Best Practice in ESMH (Lever et al., 2006)

1. All youth and families are able to access appropriate care regardless of their ability to pay.
2. Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.
3. Programs and services focus on reducing barriers to development and learning, are student and family friendly, and whenever possible, are based on evidence of positive impact.
4. Students, families, teachers, and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.
5. Quality assessment and improvement activities continually guide and provide feedback to the program.
6. A continuum of care is provided, including school wide mental health promotion, early intervention, and treatment.
7. Staff holds to high ethical standards; are committed to children, adolescents, and families, and display an energetic, flexible, responsive, and proactive style in delivering services.
8. Staff are respectful of, and competently address, developmental, cultural, and personal differences among students, families, and school staff.
9. Staff build and maintain strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.

10. Mental health programs in the school are coordinated with related programs in other community settings.

2.3.4.3 School Mental Health Organizations and Journals

A final indicator of movement and growth in school mental health are the number of organizations specific to the field. In Table 7, in order of date of conception, is a list of ten organizations and journals as they have been established over the past 28 years. These organizations promote school mental health through research, dissemination of materials, conferences, and supporting design of programs and policies.

Table 7. School Mental Health Organizations and Journals[12]

Date Established	Director and Summary
1984 - The Research and Training Center for Children's Mental Health	Center Director: Robert Friedman, PhD; Deputy Directors: Albert Duchnowski, PhD & Krista Kutash, PhD http://rtckids.fmhi.usf.edu/ Based out of **University of South Florida, Department of Child and Family Studies**. "The Research and

[12] Descriptions of each organization or journal are taken directly from affiliated websites as indicated by quotations.

	Training Center for Children's Mental Health works to strengthen the empirical foundation for effective systems of care, and improve services for children with serious emotional or behavioral disorders and their families. This mission is addressed through an integrated set of research, training, consultation, and dissemination activities."
1986 – The School Mental Health Project: UCLA's School Mental Health Project (SMHP)	Co-Directors: Howard Adelman, PhD & Linda Taylor, PhD; http://smhp.psych.ucla.edu "This national Center works to improve outcomes for young people by enhancing policies, programs, and practices relevant to mental health (MH) in school. Anyone interested can use the Center to access, online, a wealth of free resources, receive technical assistance, participate in a variety of leadership training institutes, and network with many others with shared interests." Based out of **UCLA, Department of Psychology**
1995 - National Assembly on School-Based Health Care	"Built from the grassroots up by individuals from state and federal government agencies, national and regional foundations, child health and education organizations, and SBHCs, we are a true reflection of the field we

	support. NASBHC advocates for national policies, programs, and funding to expand and strengthen SBHCs, while also supporting the movement with training and technical assistance."
1995 - University of Maryland Center for School Mental Health (CSMH)	Co-Directors: Sharon Stephan, PhD and Nancy Lever, PhD http://csmh.umaryland.edu "This national center [based out of **University of Maryland, School of Medicine**] seeks to strengthen policies and programs in school mental health to improve learning and promote success for America's youth. Through participation in and development of a broad and growing Community of Practice, the Center analyzes diverse sources of information, develops and disseminates policy briefs, and promotes the utilization of knowledge and actions to advance successful and innovative mental health policies and programs in schools. The Center works with the wide range of stakeholders invested in integrated approaches to reduce barriers to student learning, including families, youth, educators, mental health and other child system staff, advocates, legislators, researchers and government

	officials.”
1998 - Center for School-Based Mental Health Programs (CSBMHP)	Director: Carl Paternite, PhD http://www.units.muohio.edu/csbmhp/ “An important goal of this Center is to build collaborative relationships with schools and community agencies to address the mental health and school success of children and adolescents through the promotion of expanded school mental health programs and services. As a university-based Center [**Miami University, Department of Psychology**], CSBMHP is committed to ongoing applied research, pre-service education of future clinicians, in-service training of educators and mental health professionals, and direct clinical and consultative service. The website offers users information about their programs.”
2001 - Center for Health and Health Care in Schools	“The Center for Health and Health Care in Schools (CHHCS) is a nonpartisan policy and program resource center at **George Washington University, School of Public Health and Health Services**. The Center's mission is to strengthen the well-being of children and youth through effective health programs and health care

	services in schools. The Center for Health and Health care in Schools supports the good health of children and adolescents by working with parents, teachers, health professionals and school administrators to strengthen successful health programs at school. This web site combines information on key school health issues with guidance on organizational and financing challenges. High-quality school health programs are the most direct, efficient ways to assure that all children get the help they need to lead healthy and productive lives."
2002 - Mental Health Education Integration Consortium (MHEDIC) – (A branch of CSBMHP at Miami University)	"The mission of the Mental Health-Education Integration Consortium (MHEDIC) is to promote interdisciplinary collaboration and professional workforce preparation for the many disciplines involved in supporting student learning and mental health, including educators, mental health and health staff, families and youth, advocates and others."
2007 - *Advances in School Mental Health Promotion*	Journal - "The Clifford Beers Foundation, in collaboration with the University of Maryland School of Medicine, is pleased to announce the launch of a new academic journal relevant to all those with an interest in

	school mental health promotion. The inaugural issue of Advances in School Mental Health Promotion was published in October 2007, with Volume 1 commencing in January 2008. The Journal emphasizes the interconnectedness of research, policy, training and practice and the opportunities to make progress in all these areas through global dialogue, collaboration and action. Mark Weist (University of Maryland School of Medicine) and Michael Murray (The Clifford Beers Foundation) are the editors, supported by a distinguished international editorial board."
2009 - School Mental Health - A Multidisciplinary Research and Practice Journal	Journal –"… is a forum for the latest research related to prevention and treatment practices that are associated with the education system and target children and adolescents with emotional and behavioral disorders. The journal publishes empirical studies, theoretical papers, and review articles from authors representing the many disciplines that are involved in school mental health."
XXXX - Center for the Advancement of Mental	"The Center was established through a partnership between the **Missouri Department of Mental Health**

Health Practices in Schools	**and the MU Department of Educational, School and Counseling Psychology** to respond to the shift in the priorities of federal and state agencies pertaining to policy, practice and research concerning child and adolescent mental health. The center collaborates with diverse stakeholders and programs across the nation to address the mental health needs of youth. They provide resources, professional development trainings, and access to presentations and publications through the internet site."

The organizations featured in Table 7 are exclusive to the US. Globally, there is the International Alliance for Child and Adolescent Mental Health and Schools Society (Intercahms Society). Beginning to develop in 1998, the The Intercahms Society held its first inaugural meeting in 2003. Now The Intercahms Society has an international board representative of over 10 countries. With an emphasis on School Mental Health, The Intercahms Society aims to:

> … raise awareness of the mental health needs of children and young people and the ways in which service providers can meet their needs; to support parents and teachers in their actions to strengthen the health and well-being of those in their care; and to develop and adopt a common language of terms related to mental health and schools (Weare, 2004, p. 65).

In 2009, INTERCAHMS released results of a survey[13] that was conducted in 25 countries and included over 1200 school principals. Joining with the International Confederation of Principals (ICP), the survey included six main sections: a) the link between emotional/mental health well-being and school achievement; b) major student issues related to mental health; c) major staff issues related to mental health; d) policies related to mental health; e) impact of student family income; and f) the need for professional development and resources. Of importance to this review is the result that 90% of principals surveyed believed the link between mental health and academic achievement was very important.

In sum, this section has examined the history of the school mental health movement from the perspective of contributing disciplines, programs and policies, and additional indicators of movement in the field, such as foundational works and formation of professional organizations and journals. It is clear that SMH has become increasingly immersed in the context of schools. Reinforcing this direction are the 12 communities of practice within CSMH. As outlined in Table 7, School Mental Health Organizations and Journals, one of the organizations featured is The Center for School Mental Health (CSMH), the nation's leading organization advancing the field of school mental health. CSMH is comprised of 12 national communities of practice; each practice group works to ameliorate collaboration between education and mental health through research, conferences, and policy. The 12 communities include:

[13] Report of Major Findings: International Survey of Principals concerning Emotional and Mental Health and Well-Being http://www.intercamhs.org/html/principals_survey.html

1. Building a Collaborative Culture for School Mental Health
2. Connecting School Mental Health and Positive Behavior Supports
3. Connecting School Mental Health and Juvenile Justice and Dropout Prevention
4. Education: An Essential Component of Systems of Care
5. Family-School-Community Partnerships
6. Improving School Mental Health for Youth with Disabilities
7. Learning the Language: Promoting Effective Ways for Interdisciplinary Collaboration
8. Psychiatry and Schools
9. Quality and Evidence-Based Practice
10. School Mental Health for Culturally Diverse Youth
11. School Mental Health for Military Families
12. Youth Involvement and Leadership

Naturally, as the school mental health movement endeavors to build the mental health capacities of schools, all 12 communities of practice listed above are in the context of America's schools. Therefore, the next section intuitively explores literature that addresses leaders of K-12 schools. Both principals and superintendents are charged with many tasks some of which include program design, policymaking, professional development of teachers, and monitoring achievement data. Consequently, school leaders play a significant role when it comes to defining school mental health within their buildings and districts.

2.4 SCHOOL MENTAL HEALTH COMPETENCIES FOR EDUCATIONAL LEADERS

Subsequent to the previous two sections, prevalence of mental health disorders in school-aged children and the history of the school mental health movement, now comes and exploration of school mental health competencies of educational leadership. Investigating school leadership expectations of school mental health knowledge, this section answers the question: What are school mental health competencies for educational leaders? Addressing this, the first section defines competencies in the context of leadership and reveals issues surrounding the use of competency models. Following this introduction will be a review of competencies as they relate to school leadership standards.

2.4.1 Competencies and Competency Models

Research related to leadership competencies can be found in the fields of business and human resources. A review of the literature shows two encampments of authors: those touting that the success of organizations is directly tied to the strategic development and application of leadership competencies, and those heavily cautioning the use of competencies and declaring that overdependence on leadership competencies will destroy an organization. In spite of this polarization, Hollenbeck, McCall, and Silzer (2006), representatives from both positions agree that leadership effectiveness is contingent upon, "a combination of knowledge, skills and abilities that come in and out of importance in different situations and as those situations vary

over time" (Hollenbeck, McCall, & Silzer, 2006, p. 411). Competencies capture exactly which knowledge, skills, and abilities are deemed necessary for success.

A *competency* is a written statement that attempts to identify behaviors or situations that predict successful outcomes. A *competency model* is a set of organized competencies utilized to measure, train, and hire individuals specific to a position (Spicer, 2009) Competencies can be written for all levels of professionals from skilled workers to managing leaders. They help organizations by: a) "openly communicating which leader behaviors are important; b) helping to discriminate the performance of individuals: c) linking leader behaviors to the strategic directions and goals of the business; and d) providing an integrative model of leadership that is relevant across many positions and leadership situations" (Hollenbeck et al., 2006 p. 403).

Organizations may write competencies specific to behaviors or to situations. McCall and Hollenbeck (2004) describe how competencies are developed. Used initially to define professional development, competencies were first designed around a set of behavioral dimensions. In an effort to define frequently occurring behavior patterns that lead to success, analytical studies may examine one great leader or consider collectively the behaviors of many successful leaders. Either way, the goal is to extract successful patterns of behavior demonstrated in situations specific to that job, as well as behavior specific to people. Once these behaviors are identified, it is conveyed in a competency and is therefore considered a reliable and consistent property of leadership.

When creating competencies, it is helpful to understand situational variables. There are many types of situational variables that influence an organization. (Silzer, 2002b). Silzer (2002) describes these variables in the following five categories: job variables (e.g., responsibilities and

performance expectations), interpersonal dynamics (e.g., moment-to-moment interactions), team context variables (e.g., boss, peers, and direct reports), organizational culture variables (e.g., norms, history, and strategies), and country culture variables (e.g., use of power, individualism, and respect for others).

Jay Conger, a prolific writer focusing on organizational behavior, and Douglas Ready, a highly regarded advisor of CEOs around the world and founder and CEO of a leadership development partnership between 30 leading companies and 20 business school around the world, aptly describe the evolution of competencies:

> Their popularity has been so significant that they have migrated beyond developmental initiatives into performance measurement, career management, high-potential identification processes, and succession management systems, where they are used as baseline criteria for selection, promotion, and compensation (Conger & Ready, 2004, p. 42).

Today, it is not uncommon that many organizations commission a tailored set of competencies as they build capacity and capabilities that align workforce roles with strategic planning goals.

In developing competencies, organizations may have various intentions. One such reason could be for selection and training of personnel. Detailing skills important to leadership effectiveness can help an organization target just the right candidate and train accordingly (Hollenbeck et al., 2006). Another benefit of competencies is clarity. "Competencies help organizations set clear expectations about the types of behaviors, capabilities, mind-sets, and values that are important to those in leadership roles" (Conger & Ready, 2004, p. 43). A third

use of competencies is to improve consistency throughout the organization. In larger organizations, a competency model can serve as a common ladder framework for communication role expectations and descriptions. This provides a vision for the overall organization as well as individuals aspiring to be leaders in the organization. Finally, competencies can serve as a platform for formative feedback. Evaluating accountability and performance through competencies provides a uniform measure and can be moved into quantifiable data (Conger & Ready, 2004).

While there are benefits of developing competencies, the literature also offers cautions for the use of them. The first such warning is to avoid over-complicating competency models (Hollenbeck et al., 2006; Conger & Ready, 2004). The literature suggests that a strong framework limits competencies to fewer than 11, and place them into three main categories (Conger & Ready, 2004). Another danger of competencies is the idea that one person can behave perfectly in all situations. Some view defining a very complex role given 9 to 11 universal behavioral dimensions as naïve. Conger and Ready (2004) additionally recommend considering cultural differences, as well as avoiding the use of competencies in summative evaluation of individuals. Finally, allowing competencies to go stale may result in performance and feedback based on leadership qualities of the previous generation. Developing competencies oriented towards the future of an organization is critical to building a leadership program.

Next, we turn to competencies in the specific context of school leadership. Competencies for educational administrators are approved and promoted by professional organizations germane to school leadership. As such, this next section begins with a review of professional organizations supporting educational administrators, and then presents a series of standards and

competencies specific to school leadership.

2.4.2 School Mental Health Competencies for School Leaders

Beyond understanding the benefits and dangers of utilizing competencies to drive a profession and before reviewing competencies specific to school leaders, there are two points of understanding to clarify. First are the words used to reference competencies. This review has discovered several formats for illustrating expectations. Words such as *standards*, *competencies*, *functions*, *principles*, and *guidelines* can be found throughout this investigation. Typically, organizations develop standards through guiding principles as a broad expectation. Competencies and functions, on the other hand, indicate more specific behaviors or situations.

Further complicating the nomenclature is that standards can be specific to policy, practice, program, or performance. Depending upon which, this may dictate the details included for the written standard; policy standards are very broad whereas performance standards are very specific. Regardless, this review considers all standards as we look for examples of mental health competencies for school leaders.

In order to address the confusion between policy, practice and program standards, the *Educational Leadership Policy Standards: 2008* offers definitions for each.

Policy Standards "High- level, broad national standards that policy makers and states use as a model for developing their own policy standards. Policy standards are typically used for visioning,

	policy development, and identifying general goals for education leaders" (Education Leadership Policy Standards: 2008, p. 20).
Practice Standards	Practice standards are "observable behaviors and actions required to meet performance standards. They are measureable and can be used as guides to establish individual performance goals, professional development plans, and evaluation conferences within a system of continuous improvement focused on expert performance" (Education Leadership Policy Standards: 2008, p. 20).
Program Standards	"Guide curriculum planning, program and candidate assessment design, and implementation of the accreditation process for school building and district leadership preparation programs at colleges and universities undergoing NCATE accreditation" (Education Leadership Policy Standards: 2008, p. 20).

Secondly, while all of the standards, competencies, functions, and guidelines featured in this review are from professional and authentic sources, not all featured here are mandated. Many professional organizations offer such competencies hoping to influence and guide policy makers towards research-based practices.

As in most professional fields, individuals unite and create organizational bodies, which guide their profession through changing political and economic climates. These professional organizations vary in their work efforts and visible presence among the workforce for which they support. For educational administration, many such organizing bodies work to research, promote best practice, and advocate for educational administrators in all 50 states. Examples of such organizations are:

1. American Board for Leadership in Education (ABLE)
2. Council of Chief State School Officers (CCSSO)
3. National Association of Elementary School Principals (NAESP)
4. National Association of Secondary School Principals (NASSP)
5. National Policy Board for Educational Administration (NPBEA)
    a. University Council of Education Administration (UCEA)
    b. Interstate School Leadership Licensure Consortium (ISLLC) 1994
    c. National Commission on Excellence in Educational Administration
    d. National Commission for the Advancement of Educational Leader Preparation
6. National Council of Professors of Educational Administration (NCPEA)
7. National Council for Accreditation of Teacher Education
    a. Educational Leadership Constituent Council (ELCC) – Performance Based Standards to evaluate school leadership preparation programs – commissioned by NPBEA in 2000.

While the histories of such organizations are beyond the purview of this literature review, it is essential to understand the relationships and collaborative efforts of these bodies for it is from the cooperative efforts of these organizations that standards are developed. To begin, the University Council for Educational Administration (UCEA), formed in 1954, is a consortium of higher education institutions that work to build a foundation for research and best practice relevant to educational leadership. An outgrowth of UCEA is the National Commission on Excellence in Educational Administration (NCEEA), created in the early 90s with a specific goal of understanding challenges faced by the field of school leadership and proposing action to support their discoveries. One of the outcomes of this commission was the formation of the National Policy Board of Educational Administration (NPBEA). The NPBEA created the Interstate School Leaders Licensure Consortium (ISLLC in 1994). The ISLLC was then moved and housed in the Council of Chief State School Officers (CCSSO). This shift was thought to be helpful because the Interstate New Teachers Assessment and Support Consortium (INTASC) was under CCSSO and was also striving to develop standards for teachers under the direction of Linda Darling-Hammond. It is out of the ISLLC that the set of national standards and competencies for school leadership originated.

2.4.2.1 Educational Leadership Policy Standards: ISLLC 2008

Joseph Murphy, in his 2003 paper prepared for the NPBEA, *Reculturing, Educational Leadership: The ISLLC Standards Ten Years Out,* outlines for readers nine ways that at least 40 states utilize the ISLLC Standards: a) replicating their own state standards for school leadership;

b) requiring universities to align and redesign their preparation programs to the ISLLC Standards; c) modifying assessments utilized by state agencies to approve preparation programs; d) accrediting preparation programs in school administration utilizing the ISLLC Standards; e) developing licensure examinations based on the ISLLC Standards; f) organizing continuing education programs and relicensure programs; g) offering state level leadership academies and develop curriculum; and h) reforming districts school leadership assessment and evaluation. While not every state has done each of these, given this level of adoption throughout the country, one can conclude and might argue the ISLLC Standards form the basis for most contemporary school leadership competencies.

Since the initial set of ISLLC Standards in 1996, the ISLLC has released a second set in 2008. A catalyst for the revisions was, "…the recognition that when implementing the 1996 standards, some institutions used them differently, confusing policy standards with practice standards" (The Wallace Foundation, 2008 p. 6). The intent of the *Educational Leadership Policy Standards: 2008* is to reflect the most recent research related to school leadership, as well as to provide a context to examine how these policy standards may guide program and practice design (Education Leadership Policy Standards: 2008).

It is important to recognize the efforts required for the development of these highly profiled standards. [The following ten organizations are contributing members of NPBEA: American Association of Colleges for Teacher Education, American Association of School Administrators, Association for Supervision and Curriculum Development, Council of Chief State School Officers, National Association of Elementary School Principals, National Association of Secondary School Principals, National Council for Accreditation of Teacher

Education, National Council of Professors of Educational Administration, National School Boards Association, and University Council for Educational Administration.] The purpose of the NPBEA, as stated in its Bylaws, is to advance the professional standards of educational administration by collective action. In 1993, NPBEA announced two new major goals: a) to develop common and higher standards for the state licensure of principals, and b) to develop a common set of guidelines for the National Council for Accreditation of Teacher Education (NCATE) for advanced programs in educational leadership. Leaders created this later goal with the intent of offering consistent criteria to programs preparing school leaders for such an array of role responsibilities. Thus, it is important to note that in school leadership, competencies for state licensure are different from the competencies for state preparation programs.

Table 8 reflects the *Educational Leadership Policy Standards: ISLLC* 2008. In addition to explicitly defining the different kinds of standards – policy, program and practice – the ISLLC also placed the word, "policy" directly in the title so that states would not mistakenly utilize these *policy* standards as *performance* or *program* standards. Rather, these standards are to be used as a guide so that state level policy can be made specific to school leadership.

Table 8. Educational Leadership Policy Standards: ISLLC 2008[14]

Standard	Functions
1. An education leader promotes the success	A. Collaboratively develop and implement a

[14] Underlined words indicate a reference to mental health.

of every student by facilitating the development, articulation, implementation, and stewardship of a vision of learning that is shared and supported by all stakeholders.	shared vision and mission B. Collect and use data to identify goals, assess organizational effectiveness, and promote organizational learning C. Create and implement plans to achieve goals D. Promote continuous and sustainable improvement E. Monitor and evaluate progress and revise plans
2. An education leader promotes the success of every student by advocating, nurturing, and sustaining a school culture and instructional program conducive to student learning and staff professional growth.	A. Nurture and sustain a culture of collaboration, trust, learning, and high expectations B. Create a comprehensive, rigorous, and coherent curricular program C. Create a personalized and motivating learning environment for students D. Supervise instruction E. Develop assessment and accountability systems to monitor student progress F. Develop the instructional and leadership

	capacity of staff G. Maximize time spent on quality instruction H. Promote the use of the most effective and appropriate technologies to support teaching and learning I. Monitor and evaluate the impact of the instructional program
3. An education leader promotes the success of every student by ensuring management of the organization, operation, and resources for a safe, efficient, and effective learning environment.	A. Monitor and evaluate the management and operational systems B. Obtain, allocate, align, and efficiently utilize human, fiscal, and technological resources C. Promote and protect the welfare and safety of students and staff D. Develop the capacity for distributed leadership E. Ensure teacher and organizational time is focused to support quality instruction and student learning
4. An education leader promotes the success of every student by collaborating with	1. Collect and analyze data and information pertinent to the educational environment

faculty and community members, responding to diverse community interests and needs, and mobilizing community resources.	2. Promote understanding, appreciation, and use of the community's diverse cultural, social, and intellectual resources 3. Build and sustain positive relationships with families and caregivers 4. Build and sustain productive relationships with community partners
5. An education leader promotes the success of every student by acting with integrity, fairness, and in an ethical manner.	A. Ensure a system of accountability for every student's academic and social success B. Model principles of self-awareness, reflective practice, transparency, and ethical behavior C. Safeguard the values of democracy, equity, and diversity D. Consider and evaluate the potential moral and legal consequences of decision-making E. Promote social justice and ensure that individual student needs inform all aspects of schooling
6. An education leader promotes the success of every student by understanding,	A. Advocate for children, families, and caregivers

responding to, and influencing the political, social, economic, legal, and cultural context.	B. Act to influence local, district, state, and national decisions affecting student learning C. Assess, analyze, and anticipate emerging trends and initiatives in order to adapt leadership strategies

The underlined phrases are relevant to this literature review and indicate at best an indirect relation to children's mental health within the ISLLC school leadership standards. While there is reference made to aspects of school leadership such as collaboration, curriculum, technology, social justice, cultural awareness, and data collection, this set of *policy standards*, despite the urgency of children's mental health disorders, never mentions "mental health." However, one could imply that functions within Standards 2, 3, 4 and 5 to some degree could refer to mental health. Furthermore, the term "physical health" is also absent from this document.

2.4.2.2 ELCC Building-Level Standards - 2011

In addition to the ISLLC Standards, a second body commissioned by the NPBEA is the Educational Leadership Constituent Council (ELCC). The field of education administration charged ELCC with creating *performance-based* standards to evaluate school leadership preparation programs across the US. These performance standards were first published in 1995

and are housed within the National Council for Accreditation of Teacher Education (NCATE). The most recent ELCC standards are from 2011.

There are actually two sets of ELCC standards (see Appendices A and B) used for evaluating preparation programs: ELCC Building-Level Standards – 2011, and ELCC District Level Standards - 2011. These two documents vary minimally. In fact, they are nearly identical save for the use of some terminology such as "district level" or "school level", and "school-based" or "district wide," accordingly. However, each standard has several supporting "elements". In turn each element is supported by two sets of competencies: Content Knowledge and Professional Leadership Skills. While these documents do not present the term "mental health", Table 9 illustrates words or phrases that *may* encompass children's mental health. Also included in Table 9 are other skills or knowledge pieces, besides children's mental health, that *are* included in these standards.

Table 9. ELCC District/Building Level Standards – 2011: Possible Inferences to School Mental Health

Possible Inference to School Mental Health	Other Key Concepts Noted
ELCC Standard Element 2.1: Content Knowledge – "…theories on human development behavior, personalized learning environment, and motivation"	Differentiated instruction
ELCC Standard Element 3.3: "Candidates understand and can promote district-level [school-based] policies and procedures that	Curriculum – management and effectiveness

protect the welfare and safety of students and staff across the district.”	
ELCC Standard 4.1: “Candidates understand and can collaborate with faculty and community members by collecting and analyzing information pertinent to the improvement of the district’s/school’s educational environment.”	Instruction through technology
ELCC Standard 4.2: “Candidates understand and can mobilize community resources by promoting understanding, appreciation, and use of the community’s diverse cultural, social, and intellectual resources throughout the district/school.”	Accountability reporting
	Discipline management
	Cultural resources
	Social resources
	Social justice
	Equitable learning opportunities
	Emerging trends
	Economics
	Legal knowledge
	Poverty and disadvantages of

When reviewing the ELCC Standards, one might question why they have included social justice, economics, curriculum, and technology, but not children's mental health. Also concerning is the absence of an expectation of "discipline management" and a knowledge expectation of "children's mental health." Children who are typically in need of continual "discipline management" are considered at risk for a mental health disorder (Hartney, McKinney, Eidlitz & Craine, 2010). Additionally, children who are considered "poor" are also at risk for a mental health disorder (Howell, 2004).

In addition to the ISLLC 2008 policy standards and the ELCC 2011 performance standards, this review features one more set of standards from an organization situated in school leadership: *Principals Standards 2008: Leading Learning Communities: What Principals Should Know and be Able to Do.*

2.4.2.3 Principals Standards 2008: Leading Learning Communities: What Principals Should Know and be Able to Do

The National Association of Elementary School Principals (NAESP) is an organization whose members are principals in K-8 settings. Founded in 1921, NAESP members hail not only from the US, but from Canada and other countries as well. NAESP also offers a set of standards for principals, *Principal Standards 2008: Leading Learning Communities: What Principals Should Know and Be Able to Do.* This report consists of six main standards with supporting competencies for each. NAESP recognizes these as *performance guidelines* for principals, as shown in Table 10.

Table 10. *Principal Standards 2008: Leading Learning Communities: What Principals Should Know and Be Able to do*

Standard	Strategies
Standard One: Lead schools in a way that places student and adult learning at the center.	• Stay informed of the continually changing context for teaching and learning. • Embody learner-centered leadership. • Capitalize on the leadership skills of others. • Align operations to support student, adult and school learning needs. • Advocate for efforts to ensure that policies are aligned to effective teaching and learning.
Standard Two: Set high expectations and standards for the academic, social, emotional and physical development of all students.	• Build a consensus on a vision that reflects the core of the school community. • Value and use diversity to enhance the learning of the entire school community. • Broaden the framework for child development beyond academics. • Develop a learning culture that is adaptive, collaborative, innovative and supportive.
Standard Three: Demand content and instruction that ensure student achievement of agreed-upon standards.	• Ensure alignment of curriculum with district and school goals, standards, assessments and resources. • Invest in a technology-rich culture that connects learning to the global society. • Hire, retain and support high-quality teachers. • Ensure rigorous, relevant and appropriate instruction for all students.
Standard Four: Create a culture of continuous learning for adults tied to student learning and	• Invest in comprehensive professional development for all adults to support student learning. • Align the school wide professional

other school goals.	development plan with school and learning goals. • Encourage adults to broaden networks to bring new knowledge and resources to learning environments. • Provide time, structures and opportunities for adults to plan, work, reflect and celebrate together to improve practice.
Standard Five: Manage data and knowledge to inform decisions and measure progress of student, adult and school performance.	• Make performance data a primary driver for school improvement. • Measure student, adult and school performance using a variety of data. • Build the capacity of adults and students to use knowledge effectively to make decisions. • Benchmark high-achieving schools with comparable demographics. • Make results transparent to the entire school community.
Standard Six: Actively engage the community to create shared responsibility for student performance and development.	• Engage parents, families and the community to build relationships that support improved performance. • Serve as civic leaders who regularly engage with numerous stakeholders to support students, families and schools in more effective ways. • Shape partnerships to ensure multiple learning opportunities for students, in and out of school. • Market the school's distinctive learning environment and results to inform parents' choices of options that best fit their children's needs. • Advocate for high-quality education for every student.

Part of the title, *What Principals Should Know and Be Able to Do,* reflects no expectation

of children's mental health knowledge. Within Standard 2 is a possible reference to children's mental health, as highlighted above. Beyond this singular vague reference, this set of standards does not contain any reference to children's mental health.

The final two sets of competencies featured in this section derive from fields outside of education. While they may include educators as one of their intended audience, the organizations developing the next sets of competencies are not based in education. Rather contributing disciplines include social workers, nurses, psychologists, pediatricians and child development specialists.

2.4.2.4 Core Workforce Competencies for Advancing Interdisciplinary Mental Health Practices in Schools

In reviewing the literature, a set of competencies from SMH emerges. While the competencies do not address school leaders solely, they do address the *workforce advancing interdisciplinary mental health practice in schools* (i.e., social workers, nurses, educators, psychologists, and therapists.) These competencies were created in 2006 as a response to a request from the Annapolis Coalition to the Behavioral Health Workforce. The Mental Health—Education Integration Consortium (MHEDIC), then serving as a school mental health (SMH) expert panel for the Annapolis Coalition, answered the call by analyzing workforce issues specifically related to the *school-based workforce*. As a result, MHEDIC proposed five specific recommendations

as well as supporting interventions. One of the recommendations was the development of a certificate for training in *Advanced Interdisciplinary Mental Health Practice in Schools.* Of interest is that while school leaders should be considered part of the school-based workforce, many of these competencies speak to the need to engage school administrators. To illustrate this point, Table 11 displays the Core Workforce Competencies, with italics added to show references to the role of school leaders.

Table 11. Preliminary List of Core Workforce Competencies for Advancing Interdisciplinary Mental Health Practice in Schools[15,16]

Description of Competency
1. Participate effectively in planning, needs assessment and resource mapping *with families and school and community stakeholders* to develop, introduce, and sustain SMH program and services.

[15] italics added

[16] *Adapted from work underway by:
1) Center for School Mental Health Analysis and Action at the University of Maryland (grants: (a) #U45 MC00174-10-0, 2000-2005, *Achieving the Promise of Expanded School Mental Health*. MCHB, Health Resources and Services Administration; Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services; and (b) #1R01MH71015-01A1, 2003-2006, *Enhancing Quality in Expanded School Mental Health*. National Institute of Mental Health, US Department of Health and Human Services);
2) Center for School-Based Mental Health Programs at Miami University (grants: (a) #062984-6B-PB-04P05P/06, 2003-2006,
Mental Health for School Success, Ohio Department of Education; and (b) #G01085, 2005-2006, *Enhanced Ohio Mental Health Network for School Success*, Ohio Department of Mental Health);
3) Center for the Advancement of Mental Health Practices in the Schools at the University of Missouri, Columbia (portfolio development project for Master's degree program in Mental Health Practices in Schools); and
4) Collaborative for Academic, Social, and Emotional Learning (key informant interview study completed by MHEDIC colead Jennifer Axelrod, July-August, 2005).

2. *Develop and sustain relationships with school administrators*, school-employed mental health staff, teachers and support staff, families, and community partners.
3. Maintain thorough and up-to-date knowledge of major *educational initiatives* and polices that impact schools at the federal/national, state, and local level; and ensure that SMH practices align with those educational realities.
4. In all work, demonstrate an understanding of *factors influencing school culture and climate, educators' potential roles as mental health/wellness change agents.*
5. Demonstrate a thorough understanding of systems change theory and best practices and demonstrate an ability to work in complex systems.
6. Effectively represent SMH *to the school* (orally and in writing) and develop program and service delivery referral mechanisms that are responsive to local needs.
7. Implement a full continuum of school-wide mental health promotion, prevention, early intervention and treatment available to all students including those in general and special education.
8. Demonstrate an ability to sustain prioritized focus on mental health promotion, prevention, and early intervention; rather than succumbing to exclusive (or near exclusive) delivery of intensive intervention services.
9. Develop and continuously enhance communication channels and relationships *with school staff.*
10. Develop and continuously enhance strategies for outreach to students and families for services and for active program guidance.

11. Maintain appropriate student and family privacy and confidentiality, guided by standards of practice.
12. Develop and continuously enhance *collaborative relations with teachers* in working together to improve classroom environments and student behaviors.
13. *Assist teachers* in learning skills that can be shared with students that reduce mental health barriers to learning.
14. *Assist teachers* in proactively identifying students contending with stress/risk and/or presenting emotional/behavioral problems.
15. Participate effectively in school decision-making teams including those focusing on services and supports for individual students and those focusing on school improvement.
16. Participate in collaborative actions that improve the school environment and/or broadly teach students important and evidence-based life skills.
17. Implement prevention and skill training group interventions that are based on evidence of positive impact with similar students.
18. In all work, demonstrate an understanding of normal patterns of human physical, cognitive and social-emotional development, patterns of development that influence optimism and resiliency, varieties of human diversity, and how issues of diversity (culture, ethnicity, race, economics, gender) influence mental health.
19. In all work, demonstrate an understanding of differences between a deficit and strengths based model for mental health; and frame SMH programs and services in positive and proactive ways to advocate for mental wellness.

20. In all work, demonstrate an understanding of common childhood and adolescent stressors and effective coping strategies, common problems impacting development, and common mental health challenges *faced by all stakeholders connected with schools (students, staff,* and *families).*
21. Conduct integrated academic and mental health assessments in a manner that is therapeutic for students and families.
22. Appropriately use paper and pencil assessments, behavioral observations, and other measures to enhance assessment for students being considered for or in early stages of services.
23. Actively share assessment findings with students and families (and when appropriate, school staff) and involve them as active and equal collaborators in decision-making.
24. Implement preventive and supportive interventions for youth presenting needs for assistance, including those without psychiatric diagnoses, using evidence-based strategies.
25. Implement treatment for youth meeting criteria for psychiatric diagnoses using evidence based strategies.
26. Implement systematic quality assessment and improvement (QAI) strategies to monitor and continually improve the quality of all services.
27. Actively and on an ongoing basis use appropriate evaluation methods focusing on academic and behavioral outcomes that are *valued by families and schools*, and that are proximal to delivered interventions.
28. Share evaluation findings and outcome data with students, families, and school staff and

integrate their feedback into QAI planning and action.

29. *Assist the school* in developing and implementing strategies to prevent and reduce all forms of violence, as well as assist students and staff who are exposed to violence.
30. *Assist the school* in developing and implementing effective plans to prevent and respond to crises.
31. Address high-risk student problems, including reports of abuse and neglect, and suicidal and homicidal ideation and behavior.
32. Enthusiastically participate in training, supervision and ongoing coaching and supportive actions to enhance school mental health promotion and intervention competencies of all stakeholders, in all instances utilizing evidence-based approaches.

These 32 proposed competencies include many facets critical to the success of school mental health such as collaboration, sustainability, assessment, and evidence-based strategies. However, some, like competency 2 (*Develop and sustain relationships with school administrators*, school-employed mental health staff, teachers and support staff, families, and community partners.), clearly are not written for school administrators. One may infer that this is addressing only outsiders coming in to the school setting. Others, like competencies 13 and 14, could be written for school leaders. Wording throughout leaves the reader uncertain of the intended audience. What disciplines comprise the "Core Workforce?" School leaders reading these may imply that they are not included in the "Core Workforce". In sum, perhaps these competencies are intended to capture a variety of contributing disciplines. As a result, however,

of this ambiguity, readers such as school leaders may not be able to identify their own role or expectations.

2.4.2.5 Health, Mental Health and Safety Guidelines for Schools

Finally, Table 12 features a set of competencies that originated from 30 different collaborating disciplines: the *Health, Mental Health and Safety Guidelines for Schools* (2004). While the title contains the word "guidelines," this list of 33 items can be easily viewed as competencies as specific tasks, skills and roles are referenced. This set, *Health and Mental Health Services*, is one of nine modules that comprise the Guidelines. Led by the American Academy of Pediatrics and the National Association of School Nurses, over 30 different organizations and 300 health, education, and safety professionals contributed to the development of these guidelines and emphasized that they are intended as guidelines, not mandates. Also stressed in their website is that health, mental health and safety are *directly* related to achievement. Thus, they also state that these guidelines are intended for school administrators, teachers, school nurses, school social workers, psychologists and other school based personnel who detect and address the health, mental health, and safety needs of children on a daily basis.

Table 12. Health, Mental Health and Safety Guidelines: Health and Mental Health Services; Social Environment[17]

Reference Number	Guideline Brief
4-01 Student assistance teams at each site	Provide a multidisciplinary student assistance team individualized to assist each student experiencing problems (educational, behavioral, developmental, or any health- or safety-related problem). At a minimum, include a school nurse, mental health professional, the student's teachers, and school administrator on the team.
4-02 Supervision of clinical activities	Require that fully qualified, credentialed, and licensed health professionals supervise clinical health professionals and health care services. The leading clinical supervisor of the district should be part of the district's central administrative team and have formal training in management and administration.
4-03 Student access to a certified school nurse	In order to meet students' physical and emotional needs, provide daily access to an on-site school nurse. School nurses should be registered nurses who have specialization in school nursing.
4-04 The school physician	Hire, or contract with, a school physician who has training and/or experience in child, adolescent and /or school health, to work with school nurses and others on the health and safety team. The physician's function should be specified in a written agreement and may include support of school staff with health

[17] Taras H, Duncan P, Luckenbill D, Robinson J, Wheeler L, Wooley S, eds. *Health, Mental Health and Safety Guidelines for Schools*. Elk Grove Village, IL: American Academy of Pediatrics; 2004); Available at http://www.schoolhealth.org

	and safety roles, interaction with community health professionals, guidance of district policy, and/or specific clinical responsibilities.
4-05 Delegation of routine clinical services	Nurses, other school health professionals (e.g., occupational, physical, speech and language therapists), paraprofessionals, and unlicensed assistive personnel should provide only those assessments and procedures (including medical observations, dental services, and administration of medications) that are appropriate to their level of training, competency and licensure.
4-06 Mental health problems: capacity to identify, refer, manage	Have the capacity to identify students with, or at risk for, mental health problems, to refer them for assessment and interventions appropriate to their needs, and to monitor and manage their behavioral, mental health, and emotional needs at school.
4-07 Staff trained for emergencies	Ensure that at least one adult with current training in basic first aid and lifesaving techniques is available to students and staff on site and at all off-site school-sponsored activities. Skills include cervical spine protection, Heimlich maneuver, cardiopulmonary resuscitation (CPR), use of an automated external defibrillator (AED), and specialized emergency procedures for those who need them.
4-08 Child abuse reporting system	Establish and maintain a system to recognize and report suspected child abuse and neglect. Define schools' response to allegations of school employees' abuse or harassment of students.
4-09 Health-related case management	Provide case management for families of students who have complex health or safety needs, who have difficulty accessing required services, or whose needs preclude optimal participation

	or achievement at school.
4-10 Health records management system	Utilize a comprehensive records management system, either electronic or paper-based, for student health and safety information.
4-11 Crisis response team and plans	Establish a crisis response protocol to manage a crisis and its aftermath, including recovery.
4-12 Oral health services	Base the range of school-based oral health care services on the student population's needs. Services may include oral health screening, fluoride rinse programs, fluoride varnishes, dental sealants, access to dentists and/or dental hygienists, and emergency dental care.
4-13 Maintaining current student health information	Collect and assess student health information that pertains to students' functioning and safety in school prior to school entry, every 1 to 2 years thereafter, and whenever a significant change in health status has occurred. Share information with staff members whose access to the health information is necessary for maintaining student health and safety. Obtain parents' informed, written consent to share information.
4-14 Assessment of immunization status	Assess and document immunization status when a student enters school, transfers to another school, or advances to a next level of schooling (e.g., elementary to middle or middle to high school).
4-15 Identification of health/safety needs prior to school entry	Develop a system to identify, prior to school entry, those students who require assistance with a special health or safety need (e.g., new students, those returning from an extended absence, those experiencing a recent health or mental health problem, and those with one or more chronic illnesses). Re-

	assess these students' needs at least annually and modify individualized health and safety care plans accordingly.
4-16 Students with frequent or extended absences	Require a comprehensive health evaluation for students with frequent or extended absences from school.
4-17 Behaviors with underlying health causes	Assess students who are frequent users of health services, who are suspended or expelled, or who demonstrate other concerning behaviors. Use a school-based multidisciplinary assessment team to assess for potential learning, emotional, and physical health problems that often underlie such behaviors.
4-18 School health screening programs	Require health screenings on the basis of state and local mandates, public health principles, and the needs of the student population.
4-19 Administering medications in school	Adopt medication administering policies that address prescription and non-prescription medications and outline responsibilities of student, family, prescribing clinician and school staff.
4-20 Individualized health services plans	Provide written, individualized health services plans for students with special health care needs. Plans must be developed with a multidisciplinary core team and comply with federal laws.
4-21 Protocols for special medical procedures	Adopt and maintain a set of up-to-date protocols for specialized medical procedures to include as part of students' individualized health services plans. Allow modifications on a student-by-student basis when there is school nurse endorsement and written consent of the parent and of the prescribing health care provider.
4-22 Exclusion	Assess students and staff with communicable diseases, sudden

from school for illness or injury	illnesses, and serious injuries to determine the need to exclude them from school. Exclusion from school should apply to students and staff whose presence poses a significant risk to themselves or others.
4-23 Students with symptoms of poor health	Assess and refer students for a comprehensive evaluation who appear to have physical or mental health-related disorders such as sudden weight loss, eating disorders, obesity, fatigue, poor attention span, behavior change, frequent urination, toothache, and any recurring symptom (e.g., cough, abdominal pain, headaches).
4-24 Reports to the public health department	Manage and report communicable disease exposure as well as exposure to chemical, biological, or radiation hazards by complying with public health, environmental, and law enforcement codes and guidelines in local and state jurisdictions.
4-25 Confidential health records	Keep health records of students and staff confidential and in a secured environment.
4-26 Quality of health services, quality assurance	Write, review, monitor, and regularly update school health services and safety policies, procedures, and protocols so that they include current evidence-based information that optimizes care and safety.
4-27 School-based health center: needs assessment	Base the selection of physical, oral, and mental health services in a school-based health center on needs of the student population and the community.
4-28 School-based health center: community health	Coordinate and integrate services delivered at a school-based health center with those delivered by the community's health care providers.

services	
4-29 School-based health center: transitioning to community-based care	Encourage school-based health centers to teach students to be good consumers of community-based health care, recognizing that school sites will not always be available for health care.
4-30 School-based health center: other school programs	Coordinate services and education provided in all regular school health programs (e.g., school health office, classroom education) with services and education provided in school-based health centers.
4-31 – School-based health center: confidentiality	Develop policies and procedures that protect confidential student health information, yet allow for exchange of information between the school-based health center and school staff, as well as between the school based health center and community health professionals, whenever information exchange is determined to be in a student's best interest.
4-32 School-based health center: quality assurance	Develop a quality assurance program in school-based health centers that is in accordance with standards of national certifying bodies and appropriate state regulations.
4-33 School-based health center: financial stability	Require that school-based health centers establish financial plans that allow them to be sustainable beyond the period covered by start-up funding. Assist school-based health centers to establish these plans.
7-01 Healthy and safe social environment	Establish a safe, healthy social environment at school for students and staff. Each day provide each student with at least one meaningful and positive interaction with a staff person (or

	other adult). Have policies that are clearly understood by students, staff and families
7-02 Social services, mental health support	Ensure that social services and mental health support are available to all students and staff in the school setting and integrate this support into other school programs.
7-03 Recognition and referral of students under stress	Implement prevention programs that focus on recognition of stressful life situations and interventions to help students deal with these stresses.
7-04 Suicide Prevention Strategies	Actively prevent suicidal behavior by training staff and having programs that identify high-risk students and then link them to therapeutic and preventive community services.
7-05 Violence Prevention Strategies	Provide the following violence prevention and management services: (a) rules prohibiting violent and disrespectful behaviors; (b) protocols to deal with violent events; (c) links to mediation, mentoring, and therapeutic services; (d) strategies to identify students at high risk for engaging in violence; (e) staff education; and (f) evaluation of violence policies and programs.
7-06 Adjustments to psychological trauma and loss	Make accommodations and/or adjustments for students during and after experiences of psychological trauma or loss.
7-07 Actions against bullying	Establish and enforce policies that prohibit bullying, hazing, teasing, harassment, and discrimination.
7-08 Policy on student discipline	Utilize disciplinary actions that do not jeopardize students' physical health or safety, that do not harm emotional well-being, and do not discourage physical activity or other healthful behaviors. Prohibit use of food as a reward or punishment.

Each of the 41 guidelines listed above are important for school leaders. Yet, one is unable to determine how and if school leaders access and utilize these guidelines.

Although clearly written specifically for school personnel, it is difficult to determine to what degree this website or said guidelines are utilized. A search to determine how frequently these guidelines are cited in the literature resulted in fourteen works. These are listed in Table 13.

Table 13. Works Citing Health, Mental Health and Safety Guidelines

Author	Title and Journal	Reason for Reference
Barrios, L., Everett-Jones, S., and Gallagher, S. (2007).	Legal liability: The consequences of school injury. *The Journal of School Health. 77* (5), 273-279.	Used as evidence of research-based expectations
Blazer, C. (2006).	Research Capsule: Wellness Policies– Miami Dade County Public Schools.	Reference to Health, Mental Health and Safety Guidelines: Health and Mental Health Services as a recommended source for writing wellness policy.

Brener, N., Wheeler, L., Wolfe, L., Vernon-Smiley, M., and Caldart-Olson, L.,	Health services: Results from the school health policies and programs study 2006. *Journal of School Health 77*(8), 464-485.	Listed as an example of organizations collaborating to generate guidelines in the absence of any federal regulations for health services.
Brenner, N., Weist, M., Adelman, H., Taylor, L., and Vernon-Smiley, M. (2007).	Mental health and social services: Results from the school health policies and programs study 2006. *Journal of School Health 77*(8), 486-499.	Listed as an example of an organization (AAP) responding to the 2003 New Freedom Commissions call to improve and expand SMH.
Lee, S., Burgeson, C., Fulton, J., Spain, C. (2007).	Physical education and physical activity: Results from the school health policies and programs study 2006. *Journal of School Health 77*(8), 435-463.	Used as evidence of research-based expectations
Lohrmann, D. (2010).	*Creating a healthy school using the healthy school report card*. Alexandria, VA: ASCD	Used as evidence of research-based expectations

Lee, S. (2011). National Center for Chronic Disease Prevention and Health Promotion.	School health guidelines to promote healthy eating and physical activity. 60 (RR-05) 1-71.	Used as evidence of research-based expectations
Nihiser, A., Lee, S., Wechsler, H., McKenna, M., Odom, E., Reinold, C., Thompson, D., and Grummer-Strawn , L. (2007).	Body Mass Index Measurements in Schools Using schools as screening sites for BMI. *Journal of School Health 77* (10), 651-671.	Used as evidence of research-based expectations
O'Neill, J., Clark, J., and Jones, J. (2011).	Promoting mental health and preventing substance abuse and violence in elementary students: A randomized control study of the Michigan Model for Health. *Journal of School Health. 81* (6), 320-330.	Used as evidence of research-based expectations

Shapiro, S. (2008).	Addressing self-injury in the school setting. *Journal of School Nursing 24*(3), 124-130.	Used as evidence of research-based expectations
Taras, H. & Potts-Detema, W. (2009).	Obesity and student performance at school. *Journal of School Health 75* (8), 291-295.	Brief reference to recommendations regarding physical exercise.
Wright, K. (2011).	Influence of body mass index, gender, and Hispanic ethnicity on physical activity in urban children. *Journal of Specialists in Pediatric Nursing. 16* (2), 90-104.	Used as evidence of research-based expectations
Minzenberg, B. (2008).	*A content analysis of policies and procedures serving children with special school health needs in early education environments.* (Doctoral Dissertation). Retrieved from https://sremote.pitt.edu/ETD/available/etd-08042008-	

115847/,DanaInfo=etd.library.pitt.edu+

A safe and healthful environment –

Chapter 4 of Massachusetts Department of

Public Health, School Health Manual.

Seven of the 14 listed sources that cite *Health, Mental Health and Safety Guidelines: Health and Mental Health Services* are published in the *Journal of School Health.* The remaining seven works are related to physical health and published in medical journals. While these guidelines were written specifically for school personnel, one may deduce that this list of 14 works does not include any educational related journals. This may be an indicator of the lack of collaboration between the two fields.

In conclusion, this section featured five sets of standards or guidelines related to either school leadership or school mental health. Evident is the absence of the overt reference to "mental health" in any of the first three sets of standards deriving from school leadership organizations. The next set of standards, *Preliminary List of Core Workforce Competencies for Advancing Interdisciplinary Mental Health Practice in Schools*, clearly contains mental health related competencies; however, the audience for whom they are intended is unclear. The final set presented here is comprised solely of mental health competencies with the targeted audience

being school personnel. However, with only 14 works citing it since its conception in 2004, it is likely that school personnel - specifically school leadership - are not aware of or do not access these guidelines.

The principal is accountable for many responsibilities; this point is documented by dozens of studies (Hemmen, Edmonson, & Slate, 2009) and thousands of published journal articles (Catano & Stronge, 2007). However, the research literature is largely silent regarding the principal's role in school mental health. This dearth of research leads us to wonder what exactly a school leader needs to know, believe and do in order to facilitate a context that encapsulates school mental health. In spite of the now widespread prevalence of children's mental health disorders and the rapidly-expanding school mental health movement, school leaders continue to lead in absence of any concise role expectations.

2.5 SUMMARY OF REVIEW

In general, this review presents a) the prevalence of mental health disorders in school-aged children, b) the strong advancements being made in school mental health, and c) school mental health competencies for school leaders. In spite of literature detailing high prevalence rates of school-aged children's mental health disorders, evidence of a bolstered school mental health movement and a highly organized and funded field of school leadership, there remains a shortage of literature yielding any research related to school leaders and children's mental health. While

the literature reveals a broad research base endorsing the benefits of competencies and collaboration, there is no research evidence of school mental health competencies specific to school leaders. As such, a lack of such competencies for school leaders is an additional barrier to the school mental health movement.

This review contributes to the recognition that efforts made to promote school achievement through children's mental health are seemingly one-sided. In other words, the field of school mental health, while failing to specifically address school leadership shows great advancement in research and policy while the field of school leadership shows very little, if any, research related to the understanding of children's mental health. In spite of expressive voices of national organizations and government reporting on the concerned state of children's mental health, why is it that the field of school leadership has yet to address this significant issue that has direct bearing on academic achievement?

Furthermore, research studies embedded in school nursing, school psychology, child psychiatry, social work, criminal justice, heavily investigate children's mental health and the effects thereof. If 20% of children in schools will have a mental health disorder that will likely decrease their academic achievement, why hasn't the field of school leadership placed more emphasis on the understanding of children's mental health? In an examination of national trends of children and antipsychotic drugs, evidence showed that children prescribed antipsychotic drugs increased *six fold* between the years 1993 and 2003 (Olfson, Blanco, Liu, Moreno, & Laje, 2006). Increases detected mostly in preschool and adolescent aged children for mainly ADHD and depression (Conrad, 2004). This statistic alone should awaken school leaders to the realities of children's mental health and its bearing on school achievement.

The field of school leadership is highly organized and well-funded as is evidenced by two things: a) multiple foundations, such as the Wallace Foundation, The Broad Foundation, and the Fordham Foundation, fund many research initiatives in order to advance the field of school leadership, and b) the number of professional organizations and journals specific to school leadership. One of the goals of such organizations and research is to ascertain highly effective components of school leadership programs so that the field can encourage model preparation programs. One of these components is, of course, instructional content. What should preparation programs teach to future principals? The vast number and variety of responsibilities that principals undertake in reality has the school leadership field struggling to answer this question.

3.0 METHODS

3.1 STATEMENT OF THE PROBLEM

Research shows high prevalence rates for school-aged children's mental health disorders (Kessler et al., 2007; Kessler et al., 2005; Merikangas et al., 2010). Multiple studies also yield significant correlational data between children with mental health disorders and decreased student achievement (Binser & Försterling, 2002; Doyle et al 2004; Ferguson & Woodward, 2002; Rothan et al, 2009). Despite these key findings, standards generated by the field of school leadership are void of any direct expectations related to children's mental health. In other words, programs preparing school leaders may not offer any content related to children's mental health, which could inhibit principals' leadership abilities when it comes to school's mental health needs.

This dearth is a problem especially as the field of school mental health is clearly gaining momentum over the past decade. The field of school mental health has, in its research, cited educational administration as a barrier to increasing the presence of school mental health

services (Weist & Paternite, 2006). In fact, they have generated a *Preliminary List of Core Workforce Competencies for Advancing Interdisciplinary Mental Health Practice in Schools,* Table 11, in an effort to increase collaborative efforts in the school setting. Yet, the school leadership literature shows very little evidence of preparing future principals to create a context open to understanding, knowing, or facilitating school mental health.

This study explored to what extent and how principal preparation programs integrate content related to school mental health. Beyond understanding how content is integrated, this study also explored exactly what components of school mental health content are included in the preparation of school leaders. Examples of possible evidence may include pedagogical reference to crisis intervention and prevention, school mental health, communications during a crisis, mental health disorders, research correlating children's mental health and academic achievement or reference to school mental health literature.

3.2 RESEARCH QUESTIONS

To address this issue, this study proposed three research questions. Research Question 1: *To what extent do the leading principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?* Since there are currently no studies exploring whether school leadership preparation programs include school mental health content, answering this question will provide a starting point from which to consider future efforts/directions. By examining

curriculum and program descriptions, school leadership can begin to identify and describe instructional content and related experiences can address school mental health. In order to do so, this study included content analysis of syllabi and overall program goals of several leading preparation programs.

Research Question 2: *If school mental health content is included in principal preparation programs, how is the aspiring school leader exposed to school mental health content?* Beyond learning if principal preparation programs incorporate school mental health curricula, this inquiry investigated how programs exposed future school leaders to school mental health content. Providing principals with an understanding of school mental health may increase their ability to facilitate a context conducive to supporting children's mental health needs. These data derived from content analysis of syllabi, program goals, and faculty CVs.

Research Question 3: *How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?* In cases where school mental health content is evident, exploring the decisions behind the inclusion of such content within the overall curriculum design may provide direction and models for other programs. The researcher conducted one semi-structured interview in order to begin to explore this pathway. Transcriptions of the interview provided qualitative data for analysis.

3.3 METHODOLOGICAL APPROACH

In order to investigate the existence of school mental health content found in principal preparation programs' curricula, this exploratory, embedded, multiple case study employed a pragmatic, sequential mixed-methods design. Before describing the details of participants and data collection, this section describes the paradigm used as well as well as reasons for selecting these particular methods.

This method is pragmatic in nature as its "…goal is to search for useful points of connection" (Mertens, 2010, p. 36) to the researcher's line of inquiry. Therefore, this study analyzed the relationship between school leadership and school mental health.

The aim of this study was not to compare the cases featured, but rather to describe "how" concepts of school mental health were presented to students in selected principal preparation programs. Yin (2009) explains that examining several cases through multiple sources of evidence for which you *do not* pull your data collectively is known as *embedded* case study design. For this study, the main unit of analysis, or context, is principal preparation programs. As illustrated in Figure 1, within each of the five cases presented, there are three embedded subunits of analysis (Yin, 2009). These subunits included: (a) program goals and mission statements, (b) syllabi, and (c) curriculum vitae.

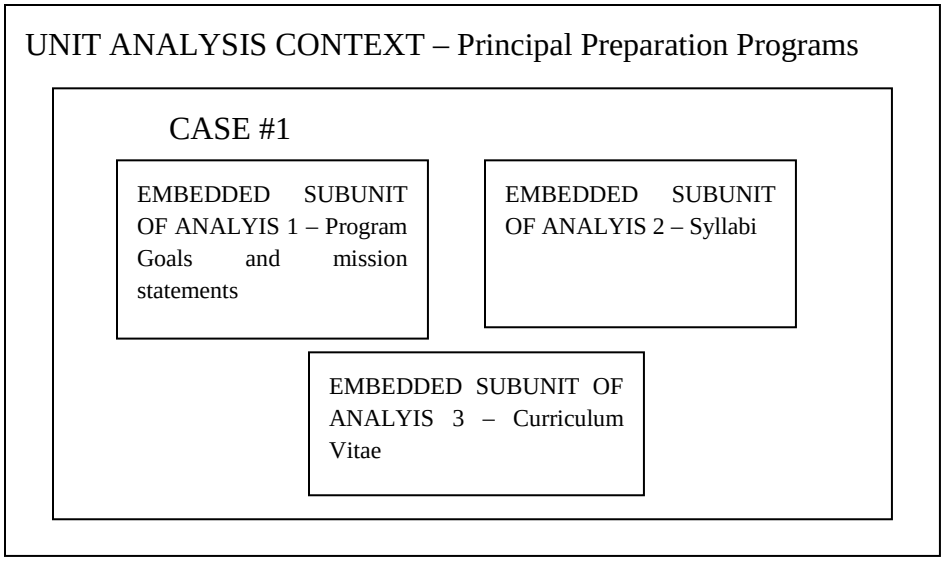

Figure 1. Embedded Case Study Unit Analysis Model

Source: Adapted from *Basic Types of Designs for Case Studies* (embedded - multiple units of analysis) Yin, 2009, p. 46.

In addition to understanding units and embedded subunits, there are two levels of inferences to consider when generalizing discoveries made through case study (Yin, 2006). As Yin (2009) explains one should "aim for level two inferences when doing case studies" (p. 39). Level one analysis is simply the description of the case study findings. A level two analysis includes policy implications as well as supporting theories. Therefore, this study did not only consider evidence at a descriptive level (level one), but also to the degree possible, investigated data on practice and policy (level two).

Because the researcher will analyze the content of documents, it is important to be aware of strengths and weaknesses when using documents as evidence. While Yin (2009) cautions that

documents may be difficult to find, carry the author's bias, or be incomplete, he lists their strengths as "1) stable – can be reviewed repeatedly, 2) unobtrusive – not created as a result of the case study, 3) exact – contains exact names, references, and details of an event, and 4) broad coverage – long span of time, many events and many settings" (p. 102).

In addition to document analysis, this study analyzed interview data. A particular strength of interviews is the ability to obtain large amounts of data in a timely manner, however, outcomes are contingent upon careful crafting of questions, time involved in analyzing the transcripts, and the importance of the valuing the subject's perspective (Marshall & Rossman, 2006).

Content analysis is a "method, *and* an analytic strategy…entail[ing] the systematic examination of forms of communication to document patterns objectively" (Marshall & Rossman, 2006), the purpose of which is to provide new insights, knowledge, and facts related to a particular phenomenon (Krippendorff, 2004). Krippendorff, a leading expert in the area of content analysis cited by over 8,600 articles, offers six steps in which the content analyst must progress when analyzing text. Krippendorff's six components of text analysis are provided in Figure 2. Krippendorff states that these steps, while listed in this order, "may include iterative loops – the repetition of particular process until quality is achieved" (p. 85). Krippendorff clusters the first four components (unitizing, sampling, recording, and reducing) together declaring them the "data making" (p. 83) steps. The final two steps (inferring and narrating) represent interpretation of the data collected.

1. Unitizing is the first step and is the selection of appropriate units relative to the topic of examination.

2. Sampling is the process of collecting units for analysis.
3. Recording is the reading and categorizing of selected text
4. Reducing is when sizable text is summarized and reduced to a more manageable replication of its meaning.
5. Inferring is when the reviewer applies a rationale for placing text into specified categories (Krippendorff, 2004). This will begin first with deductive analysis of text as it applies to the *SMH Categorization Matrix for School Leadership Documents* (Table 19). If there remains any outlying text that does not fit into the matrix, then inductive analysis will ensue in order to determine most appropriate way to amend the matrix.
6. Narrating is the final step and is the process of applying findings to what Yin (2009) would consider Level 2 Inferences. Now the researcher may interpret what the data represent in relation to the research questions by reporting on levels of text placed in each category and explaining newly created categories that may have been necessary. This step also is when the researcher addresses the research questions as well as inferring policy and practice implications.

3.4 SAMPLE

3.4.1 Program Inclusion Criteria and Selection Procedures

To generate a list of leading colleges/universities, the researcher constituted the five-case sample for this study from the *US News & World Report, Best Education Schools Rankings, 2011*. These rankings derived from a *US News and World Report* survey of 280 graduate schools, to which 238 graduate schools of education responded. Respondents provided data for 10 categories, as outlined in Table 14. The 10 categories were weighted and then the schools were ranked according to the weighted averages. *US News & World Report* researchers standardized data based on their overall mean. Standard scores were weighted, totaled, and then rescaled so that the top school earned a value of 100%.

Table 14. US News and World Report Weighted Categories for Ranking Schools of Education

Category	Subcategory
Quality Assessment (.40)	Peer Assessment (.25)
	Superintendent Assessment (.15)
Student Selectivity (.18)	Mean GRE Verbal Scores (.06)
	Mean GRE Quantitative Scores (.06)
	Acceptance Rate (.06)
Faculty Resources (.12)	Student/Faculty Ratio (.045)
	Percent of Faculty with Awards (.025)

	Doctoral Degrees Granted (.05)
Research Activity (.30)	Total Research Expenditures (.15)
	Average Expenditures per Faculty Member (.15)

US News and World Report then disaggregated this list into 10 education specialty categories. Education specialty categories included: Curriculum and Instruction, Education Administration and Supervision, Education Policy, Education Psychology, Elementary Teacher Education, Higher Education Administration, Secondary Teacher Education, Special Education, Student Counseling and Personnel Services, and Technical/Vocational. Table 15 identifies the top 20 universities listed in the Education Administration and Supervision category.

Table 15. U.S. News and World Report Graduate Schools of Education School Rankings – Education Administration and Supervision Top 20.

Institute of Higher Education
1. Vanderbilt University
2. University of Wisconsin (Madison), School of Education, Educational Leadership and Policy Analysis – Initial Principal Certification
3. Harvard University Graduate School of Education, School Leadership Program (SLP), Principal Licensure
4. Teachers College, Columbia University
5. Michigan State University

6. University of Texas – Austin, The College of Education

7. Pennsylvania State University, College of Education

8. Stanford University

9. Ohio State University

10. University of Washington

11. University of Southern California - Rossier

12. University of Virginia

13. University of North Carolina – Chapel Hill

14. Indiana University – Bloomington

15. University of Kansas

16. University of Michigan – Ann Arbor

17. University of Missouri

18. University of Maryland – College Park

19. University of Pennsylvania – Philadelphia

20. New York University – Steinhardt

This list constituted the starting point for the selection of participating programs for the purposes of the current study. Beginning with the first school, the researcher established the sample for this study. If a school did not offer a principal preparation program, than the next program listed took its place until there were a total of five schools identified as having principal preparation programs. The researcher held the names of colleges/universities confidentially and instead assigned each program a letter, A through E.

From the pool of 20 top schools of education in the United States as listed by *U.S. News & World Report,* the researcher contacted a total of 14 programs in order to fulfill the goal of five participating programs. Of these 14 programs, five principal preparation programs ultimately participated. All programs resided in institutes of higher education, graduate schools of education. Four were public schools and one was private. Prior to securing these five programs, the researcher encountered unexpected barriers when collecting documents. First, none of the websites provided course syllabi. Therefore, the researcher continued with the steps listed for retrieving syllabi, as shown in Table 17. To obtain syllabi, the researcher corresponded with program representatives by email over periods of time ranging from one day to 110 days.

Examples of other responses from programs included 1) a statement that the school no longer had a principal preparation program, 2) a statement that the program only shares syllabi with students enrolled in the program, 3) a statement that the email had been forwarded to a person in charge, and 4) an email with an attachment of all syllabi of courses required for students to receive their principal preparation certification.

3.5 DATA COLLECTION PROCEDURES

3.5.1 Retrieving Documents

To evaluate the presence of school mental health content in principal certification programs, the researcher reviewed program goals and mission statements, course syllabi, and faculty curriculum vitae. This section explains how the document retrieval process took place.

3.5.1.1 Program Goals or Objectives, Mission Statements, or Program Description

A written description of overarching goals and purpose of a program is common. However, this information may be labeled using a variety of different terms. For example, "program goals", "program objectives", "mission statement" and "program description" are titles that capture similar summaries of a program's aspirations. The wording of such text is of interest to this study because the wording conveys how a program promotes its intentions. "If a mission statement is effective as suggested by literature, it should unify the behaviors and decisions of the organization towards the same end" (Davis, Ruhe, Lee, & Rajadhyaksha, 2007, p. 101). Table 16 demonstrates steps used in this study to retrieve program goals or objectives, mission statements, or program descriptions.

Table 16. Steps Used to Retrieve Program Goals and Mission Statements

Step	Description
1.	In a search engine, enter name of university school of

education.

2. Locate and click on “Academic Programs” or “Programs.”
3. Visually scan page and click on option such as, “school leadership” or “Principal Licensure” or “Principal Fellowship Program” or “Principal Program.”
4. Visually scan for “Program Goals,” “Program Objectives,” “Mission Statement,” or “Program Description.”
5. Cut and paste relevant text into a word document for text analysis.
6. Clearly cite the source and location of text.
7. If none of these documents are available on the university website, then call the department in which the program is based in to retrieve name and contact information of program coordinator. Record contact information.
8. Email program coordinator to request in writing “Program Goals,” “Program Objectives,” “Mission Statement,” and/or “Program Description.”

3.5.1.2 Course Syllabi

Because syllabi at the higher education level contain course information, grading information, instructor information and policy information (Doolittle & Siudzinski, 2010) these are considered appropriate descriptive documents representing course content. Utilizing a syllabus as a unit of analysis is therefore viewed by the researcher as an authentic representation of course offerings. Included in Table 17 are additional steps to retrieve course syllabi.

Table 17. Steps to Retrieve Course Syllabi

Step	Description
1.	Visually scan and locate words such as, "Course Requirements" or "Curriculum."
2.	If a course listing is available, retrieve and file any syllabi that accompany the course title.
3.	If no syllabi are available, attempt to enter the course number and title in a search engine.
4.	If no syllabi surface through a search, than email the program director as outlined above.
5.	If no reply, call the department and inquire with personnel about the most efficient way to retrieve the syllabi.
6.	If at any time a response is received communicating that the program does not share syllabi, or that individual instructors must decide whether to

	participate, then record such information and respond accordingly. For example, if given the instructor's contact information, then contact the individual for the syllabus. If not given the contact information, then await a response from the instructor.

3.5.1.3 Curriculum Vitae

Curriculum vitae (CV) documents were also selected as a unit of text analysis. The CV document showcases an individual's qualifications and accomplishments that render them qualified to instruct a particular course. Of interest to this study was evidence of faculty members in each program who might have experience related to school mental health. This included education and training or professional experiences in social work, psychology, professional counseling, special education, or research topics related to school mental health.

Table 18. Steps to Retrieve Curriculum Vitae

Step	Description
1.	In a search engine, enter: "Name of University School of Education."
2.	Locate and click on "Academic Programs" or "Programs."
3.	Visually scan page and click on option such as, "school leadership" or "Principal Licensure" or "Principal Fellowship Program" or "Principal

Program."

4. Visually scan and locate words such as, "Course Requirements" or "Curriculum."
5. If a course listing is available, retrieve and file any curriculum vita that accompanies the name of the instructor.
6. If curriculum vitae are not available, but the instructor's name is listed, enter, "instructor name CV" into a search engine.
7. If no curriculum vitae surfaces through a search, than email the program director to request curriculum vitae of instructor(s).
8. If no reply in three days, resend recruitment email to the same person.
9. If no reply, call the department and inquire with personnel about the most efficient way to retrieve curriculum vitae
10. If, at any time, a response is received communicating that the instructor does not share their curriculum vitae, or that it will up to individual instructors must make the decide if the will participate, record such information and proceed accordingly.

3.5.2 Semi Structured Phone Interviews

Once program goals and mission statements, syllabi, and each curriculum vitae were examined in every case, the researcher contacted only those programs having some evidence of school

mental health content. Initially, the researcher sent an email to the program director describing the study and inviting participation in a 20-minute semi-structured interview. If there was no reply after three days from the email, then the researcher made a phone call directly to the program director. Subsequent semi-structured, phone interviews took place given the arranged time. Participants received a 20$ Visa™ gift card for their time. This in no way was contingent upon information shared, but served rather as reimbursement for the professional time of participants. If the program director failed to reply via email or phone or declined the interview, this was noted in the case record.

3.5.3 Measurement Tool and Indexing of Text

Sequential data analysis first took place to review documents and then to seek interviews of program directors for those programs showing evidence of school mental health content. Data analysis was both deductive and inductive in nature. While there is no previous research addressing the phenomenon of school mental health content in principal preparation programs, there was significant research from which to build a categorization matrix tool directing the analysis of text for such content. However, the reviewer had to monitor and adjust the categories when qualifying text appeared.

In order to create the categorization matrix tool and to increase content validity, which accurately reflects school mental health keywords and concepts, the researcher relied on experts in the field. The index created for this study has its roots in the *School Mental Health Quality*

Assessment Questionnaire[18] (SMHQAQ, 2010)(Appendix C) as well as consultation with experts in the field. The SMHQAQ features 10 principles with supporting categories and sub questions. Inductive analysis facilitated the consolidation of the 10 principles into four dimensions: a) service and practice, b) evaluation and assessment, c) access to services, and d) communication and collaboration between all stakeholders. For purpose of this study, these dimensions are viewed as equally important and in no way represent central or peripheral degrees of relativity. A fifth dimension, "Themes and Content," captured any occurrence of content words not captured through this protocol.

When keywords, concepts, or phrases appeared in each document, they were categorized according to the most appropriate dimension. This indexing system allowed not only for analysis of frequency of each occurrence, but also for subsequent visual depiction (e.g., l bar graph) representing dimensions of school mental health found in the documents.

Table 19. SMH Text Categorization Matrix for School Leadership Documents

Dimension	Sample of possible keywords/topic areas	Keywords recorded
Dimension 1: Services and Practice	Evidence-Based Practice Screening Prevention Assessment of	

[18] The Center for School Mental Health received funding The National Institute of Mental Health from 2003-2006. One of the outcomes of this grant was the *School Mental Health Quality Assessment Questionnaire* (SMHQAQ), (2010). This document is in the public domain. It is a formative assessment tool available to schools to help measure strengths and needs of their school mental health program.

	students/families/school/community needs
	Intervention
	Continuum of Care
	Referral Process
	Training and support
	Service Delivery
Dimension 2: Program Evaluation and Assessment	Program Quality
	Quality Assessment and Improvement
Dimension 3: Access	Access to Care
	Funding
Dimension 4: Communication and Collaboration	Stakeholder involvement and feedback
	Interdisciplinary Collaboration
	Interdisciplinary Communication
	Community Coordination
	Community Communication
Dimension 5: Themes and Content	Disorders (A-Z)
	Response to Intervention (RtI)
	Positive Behavior Interventions and Supports (PBIS)

In addition to quantifying data from document analysis, the researcher conducted semi-structured interviews of program directors of programs with evidence of school mental health related concepts. The researcher recorded, transcribed and analyzed the interview text. In order

to address research question 3, *How do the faculty of the leading principal preparation programs characterize the factors that have led to the inclusion of mental health content in their preparation programs,* it was necessary to question program directors in order to determine influential factors which led to the inclusion of school mental health content. Three interview questions were asked: a) How long has this content been included in your program, b) Who or what influenced the decision(s) to include this content in the program, and c) Do you plan to expand/contract this content in the future? If so, why? As is the nature of semi-structured interviewing, follow up questions were asked according to answers provided. Interview data were transcribed and qualitatively analyzed for patterns or pathways of the inclusion of school mental health content in the curriculum.

3.6 DATA ANALYSIS PROCEDURES

Text analysis utilizing the *SMH Categorization Matrix for School Leadership Documents* is iterative in nature. Therefore, in compliance with Krippendorff's (2004) procedures for text analysis, text related to school mental health unitized, sampled and then categorized according to *SMH Categorization Matrix for School Leadership.* The reviewer systematically categorized and quantified occurrences of words or phrases related to school mental health. Each case had its own matrix reflecting the contents of documents. This is known as the evidentiary base. Throughout the review of documents, the researcher continue analysis of text units in the

evidentiary base to demonstrate case findings. Following the analysis, the researcher considered inferences and interpretations for practice and policy implications.

Additionally, the researcher recorded, transcribed, and then analyzed interview data for pathways describing “how” and “why” programs included school mental health content in their curriculum.

4.0 RESULTS

The primary aim of this exploratory study was to examine the presence of school mental health terms and concepts in higher education programs that prepare and certify principals. Content analyses of syllabi and overall program goals of five principal preparation programs were examined to answer the questions, "*To what extent do leading principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students*?" "*If school mental health is included in principal preparation, how is the aspiring school leader exposed to mental health content?"* and "*How do faculty member characterize the factors that have led to the inclusion of school mental health content in their principal preparation program?"*

Text data comprised the analysis from a review of 46 syllabi and 5 program mission statements. A "text unit" is a phrase that contains evidence of text related to the topic of choice. For this analysis, the topic was school mental health. Interestingly, on the first review of text there were no text units directly citing "school mental health" or "children's mental health" or "mental health." On the second examination of text, 161 text units *related* to school mental health fell under one of five dimensions of the *SMH Categorization Matrix for School Leadership Documents*. The researcher placed each text unit in only one dimension of the matrix. Note that Program C offered electives choice to students seeking to fulfill requirements

of certification. Because some courses were electives, one does not know with certainty that any students enrolled in them. Therefore, the data appear with and without the elective courses.

Table 20. Documents Collected and Units Cited Per Program

	Syllabi		Program Statements		Curriculum Vitae	
	Documents	Units	Documents	Units	Documents	Units
Program A	12	51	1	0	4	41
Program B	4	9	1	0	3	131
Program C[a]	6	47	1	0	2	0
Program D	10	27	1	0	30	43
Program E	12	27	1	0	4	6
Total	46	161	5	0	43	221

[a]The data featured for Program C does *not* include the syllabi of two elective courses reviewed.

Categorization of data resulted in Table 21 and Figure 2, which feature the complete evidentiary base according to School Mental Health Dimensions. Dimension 1, Services and Practice, represented 42% of the evidentiary base. The second most prevalent text representation (without Program C's electives) was Dimension 4, Communication and Collaboration at 24%. There was no text addressing Dimension 3, Access.

Table 21. Total Units Recorded According to SMH Dimension and Frequency

	Without Electives	With Electives

	(*n* =161)		(*n* = 221)	
SMH Dimension	Units Identified	%	Units Identified	%
Dimension 1 – Services and Practice	68	42.2	100	45.2
Dimension 4 – Communication and Collaboration	39	24.2	41	18.6
Dimension 5 – Themes and Content	31	19.3	52	23.5
Dimension 2 – Program Evaluation and Assessment	23	14.3	28	12.7
Dimension 3 - Access	0	0.0	0	0.0

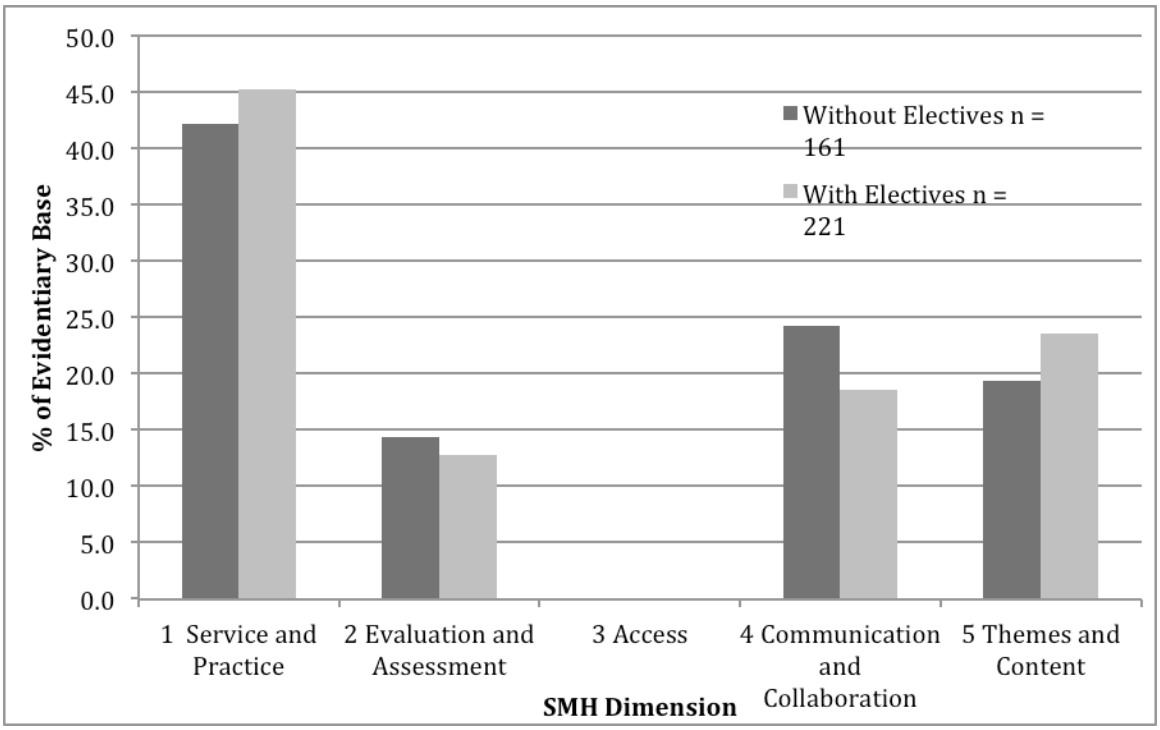

Figure 2. Syllabi: Aggregate Data According to SMH Dimension

In addition to categorizing text units by SMH Dimension, an inductive analysis of the 161 text units yielded 14 topics related to school mental health. One hundred and fifty two individual words *qualified* for the 14 topics. Lemmatization[19] applied throughout the analysis allowed words with derivatives of the root word to be included. When considering the data, *including* Program C electives, 206 words qualified for the 14 topics. The divisor for this analysis was not the total number of text units. Rather, the researcher based the percentages on the number of words qualifying for all 14 topics within each program. For example, "Consultation,

[19] Lemmatization is the grouping of all words including any derivatives that may appear.

Collaboration and Teamwork for Students with Special Needs" is one text unit. However, "Collaboration" and "Special Needs" qualify for two of the 14 SMH Topics.

Of the 14 topics listed in Table 22, categories representing the two *lowest* rates of prevalence are communication (2%) and at-risk/high-risk (3%). When considering the data including electives from Program C, categories representing the lowest rates of prevalence remained the same - communication (2%) and at-risk/high-risk (2%).

The three categories with the highest frequency rates, not including electives, are: special education (17.8%), community (13.8%), and school culture (11.8%). The five most prevalent of the 14 SMH topics identified account for over 50% of the evidentiary base. These include special education (18%), bullying (15%), community (14%), school culture (12%), and discipline (14%). Moreover, when analyzing text units *including electives* the three categories representing the most prevalent topics were bullying/cyber bullying/victimization (26.7%), special education (13.1%), and community (10.2%).

Table 22. Syllabi: Total Word Frequencies and Percentages According to 14 SMH Topics

	Totals Without Electives (n = 152)		Totals With Electives (n = 206)	
SMH Topic	*f*	%	*f*	%
Special education/special populations/special needs/disabilities	27	17.8	27	13.1
Community	21	13.8	21	10.2

School culture	18	11.8	18	8.7
Bully/cyber bully/victimization	15	9.9	55	26.7
Discipline	13	8.6	13	6.3
Collaborate	10	6.6	10	4.9
Child Abuse	9	5.9	10	4.9
Family/parent	9	5.9	10	4.9
Safety	6	3.9	16	7.8
School climate	6	3.9	7	3.4
Sexual violence/sexting	6	3.9	6	3.2
Sexuality	6	3.9	6	3.2
At risk/high risk	4	2.6	4	1.9
Communicate/communication	2	1.3	3	1.5

Finally, this study considered aggregate data representing the 14 SMH Topics within all examined curriculum vitae or biographies. Figure 3 clearly demonstrates that Community and Special Education constitute the two topics with the highest prevalence. Interestingly, this reflects the top two SMH topics identified in the review of syllabi.

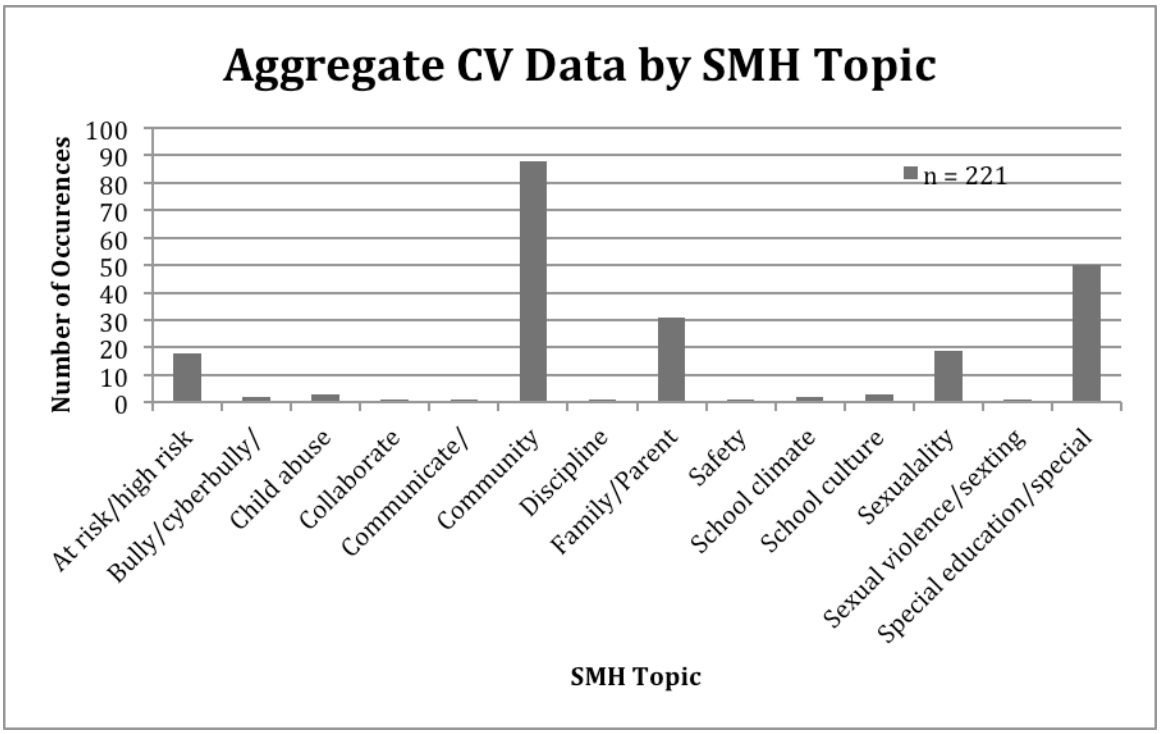

Figure 3. Curriculum Vitae: Aggregate Data According to 14 SMH Topics

In addition to analyzing aggregate data, it is important for this study to examine the data by individual cases. The disaggregate data that follow is sequenced from Program A to Program E. The next sections provide the reader with a general description of individual cases followed by individual case data addressing each research question.

4.1 PROGRAM A

4.1.1 To what extent do leading principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?

Program A resides in a public Institute of Higher Education that is located in the southwest United States. It is in an urban area and housed in a graduate school of education. This school of education has approximately 1200 students 60% of whom are full-time and 8% of whom are enrolled in education leadership and administration programs. Program A supports two cohorts in two separate cities. This program requires a completion of 45 "hours," which is equivalent to 15 three-credit courses. For Program A, the graduate internship equates to 6 hours, and another administrative class consumes 6 hours. The researcher reviewed 12 documents for this program.

Program A's Program Overview and Mission Statement revealed no occurrences of "school mental health", "children's mental health", or "mental health" with no text evidence applicable to the SMH Dimensions. The term "collaborate" and "community" were present two times each but used in the context of students' cohort or learning communities. Otherwise, there were no occurrences of text representative of the 14 SMH Topics.

Program A offered thirteen documents for review. Twelve of these documents were syllabi, of which ten contained some evidence of text related to school mental health. An examination of 51 text units for Program A yielded results as listed in Table 23. Thirty-seven percent, or 19 text units, represented Dimension 5, Themes and Content. Thirty-three percent, or 17 text units, represented Dimension 1, Services and Practice.

Table 23. Program A: Text Units According to SMH Dimension

SMH Dimension	Units Identified	%
Dimension 5 – Themes and Content	19	37.3
Dimension 1 – Services and Practice	17	33.3
Dimension 4 – Communication and Collaboration	10	19.6
Dimension 2 – Program Evaluation and Assessment	5	9
Dimension 3 – Access	0	0

Note. $n = 51$

Upon further review of the 51 text units identified in Program A, 63 words qualified for the 14 SMH topics. As shown in Table 24, "special education/special populations/special needs" accounted for over a quarter of the qualifying words. While three other cases had this topic in the their top five, Program A had the highest in this category. The second most frequent SMH topic in Program A was "school culture" making up for approximately 14% of words identified.

Table 24. Program A: Word Frequencies and Percentages According to 14 SMH Topics

SMH Topic	*f*	%
Special education/special	17	27.0

populations/special needs/disabilities		
School culture	10	15.9
Collaborate	7	11.1
Discipline	6	9.5
Community	6	9.5
Bully/cyber bully/victimization	5	7.9
School climate	3	4.8
Sexuality	3	4.8
Family/parent	3	4.8
At risk/high risk	1	1.6
Child Abuse	1	1.6
Safety	1	1.6
Communicate/communication	0	0.0
Sexual violence/sexting	0	0.0

Note. $n = 63$

4.1.2 If school mental health is included in principal preparation programs, how is the school leader exposed to school mental health content?

Studying the context of each identified text unit within the syllabus allows one to identify how aspiring school leaders may be exposed to school mental health content. While there was not one format for syllabi either within programs or across programs, there were common headings such as course introduction, course objective, required readings, and topics. The researcher sorted text units according to the heading or subheading of the syllabi from whence they were located. Since all text units were coded for syllabi context, the total number of text units in each program was used as the divisor.

The syllabi headings listed in Table 25 are exclusive to Program A. This set of 12 documents varied greatly in format. Examples of headings included course description, objectives, calendar matrixes with course topic and assignment, alignment to ISLLC Standards, professional conduct, and required text. The researcher did not combine like headings, such as "Reading" and "Required Reading" to avoid misinterpretation of instructor expectations. Rather, the text units in Table 25 are reported exactly as cited in syllabi.

Table 25. Program A: Text Units According to Syllabi Context

Syllabi Context	*f*	%
Reading	11	21.6
Topic	11	21.6

Guiding question	7	13.7
Course objective	5	9.8
Assignment	3	5.9
Course introduction	3	5.9
Class activity	2	3.9
Course content	2	3.9
Guest speaker	2	3.9
Required reading	2	3.9
Field-based learning	1	2.0
Post survey	1	2.0
Recommended reading	1	2.0

Note. $n = 51$

An example of a "guiding question" was, "why study school culture?" An example of a text unit listed as a "class activity" was, "What does equity look like for a student with special needs?" An example of text evidence listed under "guest speaker" was "FBA Development." There were examples of extended narratives could be found in "course introductions" and "course objectives." One such example coded as "course introduction" was, "students with special needs are typically dependent for success upon individual interventions."

Of significance, for Program A is the prevalence of "special education/special populations/special needs;" this topic was cited 17 times. This data point is the most robust when considering the evidentiary base without electives. Moreover, not only does this topic

appear in multiple syllabi (3 of 12), but it also spans the contexts of those courses. It was cited as a "class activity," "topic," "reading," "course introduction," "course objective," and "course description."

"School culture" was coded in four syllabi contexts – "course objective," "topic," "guiding questions," and "readings." Furthermore, "discipline," cited 6 times and ranked second highest frequency in this program, coded in three different contexts – "topic," "reading," and "guest speaker." The fact that these terms span syllabi contexts may indicate a high degree of inquiry and learning.

4.1.3 How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?

In cases where school mental health content is evident, exploring the decisions behind the inclusion of such content within the overall curriculum design might provide direction and models for other programs. For this reason, the researcher conducted semi-structured interviews of program directors. Unfortunately, the program director for Program A was not available during the time of this study.

In summary, of the 51 identified text units, Program A had 0 occurrences of "school mental health." Of the 14 SMH Topics, Special education/special populations/special needs (27%), School culture (23%), discipline (14%), bullying (12%), collaboration (12%), and community (9%) ranked first, second, third, fourth, and fifth respectively.

4.2 PROGRAM B

4.2.1 To what extent do leading principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?

Program B resides in the Midwest region of the United States. An urban dwelling, this public Institute of Higher Education exceeds 35,000 students. The school of education featuring Program B has a little over 1000 students, 67% of who are full-time in 2011, and just less than 100 full-time faculty. Twenty-five percent of these students enrolled in programs related to education administration and supervision.

Program B offers two programs simultaneously. One is "on campus" and the other is "off campus." Each program is limited to 20 students. Students have the option of coupling their certification with a master's degree. Twenty-four credits, or eight courses, constitute the certification of principals. This program requires two years to complete for those taking two courses a term.

Program B's Program Overview and Mission Statement revealed no occurrences of "school mental health", "children's mental health", or "mental health" with no text evidence applicable to the SMH Dimensions. Furthermore, there were no occurrences of text representative of the 14 SMH Topics.

Individual instructors corresponded and shared the documents for this program, including four out of eight total syllabi. Three of the four available syllabi contained evidence of text related to school mental health. The researcher read, categorized into SMH Dimension and SMH Topics and analyzed nine text units. Table 26 exhibits three of the five dimensions represented in Program B.

Table 26. Program B: Text Units According to SMH Dimension

SMH Dimension	Units Identified	%
Dimension 4 – Communication and Collaboration	5	55.5
Dimension 1 – Services and Practice	2	22.2
Dimension 5 – Themes and Content	2	22.2
Dimension 2 – Program Evaluation and Assessment	0	0
Dimension 3 - Access	0	0

Note. $n = 9$

A review of the nine text units identified in Program B revealed eight words that qualified for the 14 SMH topics. As indicated in Table 27, “communicate,” “discipline,” and “family/parent” were each cited two times.

Table 27. Program B: Word Frequencies and Percentages According to 14 SMH Topics

Topic	*f*	%
Communicate/communication	2	25.0
Discipline	2	25.0
Family/parent	2	25.0
Child Abuse	1	12.5
Community	1	12.5
At risk/high risk	0	0
Bully/cyber bully/victimization	0	0
Collaborate	0	0
Safety	0	0
School climate	0	0
School culture	0	0
Sexual violence/sexting	0	0
Sexuality	0	0
Special education/special populations/special needs/disabilities	0	0

Note. $n = 8$

4.2.2 If school mental health is included in principal preparation programs, how is the school leader exposed to school mental health content?

Within the four syllabi reviewed from Program B, three syllabi contexts surfaced; "topic," "reading," and "course objective." Examples of text units coded as a "topic" included "child abuse," "student discipline," "and community conditions." One of the required readings addressed what was unique about special education administration.

4.2.3 How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?

With only half of the syllabi made available for review, the researcher was unable to consider the holistic nature of the program. Therefore, the researcher did not contact the program director.

4.3 PROGRAM C

4.3.1 To what extent do principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?

Program C resides in a private Institute of Higher Education that is located in the northeast of the United States. The Program of interest is in an urban area and housed in a graduate school of education. This school of education has approximately 900 students 90% of whom are full-time and 25% of whom are enrolled in programs related to education leadership and administration.

Program C generally requires the completion of eight courses, or 24 credits, for principal licensure. However, prior coursework may reduce the number of required courses for a student; moreover, fewer courses may be completed based on the level of the certificate sought. The program allows for adjustments to required coursework. The six courses required in Program C are constant, while students select the remaining credits based on individual preference or interest.

A review of one document that represented Program B's Program Overview and Mission Statement resulted in no occurrences of "school mental health", "children's mental health", or "mental health" with no text evidence applicable to the SMH Dimensions. Furthermore, there were no occurrences of text representative of the 14 SMH Topics.

The researcher reviewed eight syllabi in Program C's principal licensure courses. Of these, six were core courses with the remaining two as elective courses. Notably, this program offers a bank of more than 12 elective courses available for student selection; not all 12 elective

syllabi were available, however. Interestingly, a review of this list yielded two more courses with *titles* relative to SMH. The researcher was unsuccessful in retrieving these documents.

Given the six syllabi and two elective syllabi reviewed for Program C, four documents contained text units related to school mental health. The researcher identified 161(221)[20] text units, read, and categorized units according to SMH Dimensions and SMH Topics. While Dimension 3 –Access and Dimension 4 – Communication and Collaboration were not represented, Dimension 1 – Services and Practice comprised close to 83% of text units identified as can be seen in Table 28. Examples of text units qualifying Dimension 1 included; "questions and answers on discipline procedures," "student safety and well-being," and "effective strategies to combat bullying."

Table 28. Program C: Text Units According to SMH Dimension

	Without Electives *n* = 46		With Electives *n* = 107	
SMH Dimension	Units Identified	%	Units Identified	%
Dimension 1 – Services and Practice	38	82.6	70	65.4
Dimension 5 – Themes and Content	5	10.9	26	24.3

[20] The first number represents total units without elective course data. The number in includes additional data from elective course syllabi.

Dimension 2 – Program Evaluation and Assessment	3	6.5	9	8.4
Dimension 3 - Access	0	0.0	0	0
Dimension 4 – Communication and Collaboration	0	0.0	2	1.9

A review of 46 text units identified in Program C without electives revealed 35 words that qualified for the 14 SMH topics. Furthermore, a review of 107 text units identified in Program C *including* electives showed 89 words that qualified for the 14 SMH topics. As demonstrated in Table 29, "bully/cyber bully/victimization" generated 29% of the identified words. Paired with data from elective coursework, this percentage nearly doubled to over 55%. This was because one of the electives reviewed was exclusive to the topic of bullying. Unlike Program A which proved zero frequency for only one topic, Program C revealed 0 evidence for six topics.

Table 29. Program C: Word Frequencies and Percentages According to 14 SMH Topics

	Without Electives (n =35)		With Electives (n = 89)	
Topic	*f*	%	*f*	%
Bully/cyber	10	28.6	50	56.2

bully/victimization				
Child Abuse	6	17.7	7	7.9
Special education/special populations/special needs/disabilities	4	11.4	4	4.5
Discipline	3	8.6	3	3.4
Safety	3	8.6	13	14.6
Sexual violence/sexting	6	5.7	6	6.7
Sexuality	2	5.7	2	2.2
At risk/high risk	1	2.9	1	1.1
Collaborate	0	0.0	0	0.0
Communicate/communication	0	0.0	1	1.1
Community	0	0.0	0	0.0
Family/parent	0	0.0	1	1.1
School climate	0	0.0	1	1.1
School culture	0	0.0	0	0.0

4.3.2 If school mental health is included in principal preparation programs, how is the school leader exposed to school mental health content?

As Table 30 reveals, students in Program C received school mental health related content primarily through required readings. Focus questions, representing eight text units in one of the syllabi, appeared in the syllabi as guiding questions to perhaps to provoke students' thinking about a particular module or topic. It follows, then, the course overview and goals as well as course and class topics reflected school mental health content to some degree.

Table 30. Program C: Text Units According to Syllabi Context

	f	%
Required reading	65	60.7
Focus question	8	7.4
Course overview	7	6.5
Topic	7	6.5
Class topic introduction	7	6.5
Course goal	4	3.7
Recommended reading	3	2.8
Final project	3	2.8
Class title	2	1.9
Assignment goal	1	.9

Note. n=107. These total *include* electives reviewed for Program C

To summarize, the data from Program C reflect dimensions and topics with and without elective syllabi. Learning of this content seemed to occur primarily through required readings. Furthermore, Program C out of any program had the greatest number of text units that qualified for Dimension 1 – Services and Practice. Like all other programs reviewed, there was zero text units addressing Dimension 3 – Access.

4.3.3 How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?

Program C's program director was not available for an interview about this program, so one cannot determine the factors that led to the inclusion of school mental health content.

4.4 PROGRAM D

4.4.1 To what extent do leading principal preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?

Program D exists in a graduate school of education in an Institute of Higher Education of over 50,000 students. Approximately 20% of the 1000 students in this graduate school of education enrolled in an education administration and supervision program. Residing in an urban area of the Midwest region of the United States, Program D accommodates full-time and part-time

students seeking licensure. This program also offers options for students who are working on their graduate or doctoral level degrees.

A review of one document that represented Program D's Program Overview and Mission Statement resulted in no occurrences of "school mental health", "children's mental health", or "mental health" with no text evidence applicable to the SMH Dimensions. Furthermore, there were no occurrences of text units representative of the 14 SMH Topics.

Program D offered 10 syllabi for review. The researcher identified 27 qualifying text units from six of the syllabi for analysis. The researcher read and categorized text units into SMH Dimension and SMH Topics.

As confirmed in Table 31, of all cases reviewed, Program D had the highest frequency (55%) of text units in Dimension 4 – Communication and Collaboration. Of interest though, is the 0 occurrence in this program of the word "communication" and the only three occurrences of "collaboration." This is because other text qualifying for Dimension 4 included "participation", "building school-community partnerships," and "mobilizing community resources."

Table 31. Program D: Text Units According to SMH Dimension

SMH Dimension	Units Identified	%
Dimension 4 – Communication and Collaboration	15	55.5
Dimension 2 – Program Evaluation and Assessment	6	22.2
Dimension 1 – Services and	3	11.1

Practice		
Dimension 5 – Themes and Content	3	11.1
Dimension 3 - Access	0	0

Note. $n = 27$

A review of the 27 text units identified in Program D uncovered 24 words that qualified for the 14 SMH Topics. Similar to Program A, "community," "school culture," and "collaborate" rank within the top five SMH Topics. As displayed in Table 32, there was no evidence found for seven SMH Topics. Notably, the topic of bullying/cyber bullying, victimization, cited in three other programs 5 to 10 times, had zero occurrences in this program.

Table 32. Program D: Word Frequencies and Percentages According to 14 SMH Topics

Topic	*f*	%
Community	9	37.5
School culture	7	29.1
Collaborate	3	12.5
Family/parent	2	8.3
Discipline	1	4.1
School climate	1	4.1
Special education/special populations/special needs/disabilities	1	4.1

At risk/high risk	0	0.0
Bully/cyber bully/victimization	0	0.0
Child Abuse	0	0.0
Communicate/communication	0	0.0
Safety	0	0.0
Sexual violence/sexting	0	0.0
Sexuality	0	0.0

4.4.2 If school mental health is included in principal preparation programs, how is the school leader exposed to school mental health content?

Program D conveys school mental health content in its syllabi through course topics and the accompanying assignments, rubrics, and student outcomes as viewed in Table 33.

Table 33. Program D: Text Units According to Syllabi Context

Syllabi Context	*f*	%
Topic	8	29.6
Assignment	5	18.5
Student outcomes	5	18.5
Rationale	3	11.1

Rubric	3	11.1
Required text	2	7.4
Written assignment	1	3.7

Note. $n = 27$

Just as Program A shows strong evidence of "school culture", text analysis reveals a strong emphasis on "community" from Program D. Within one syllabus, this term was identified in several contexts including, "rationale," "required text," "assignment," and "topic."

4.4.3 How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?

Program D's program director was not available for an interview about this program, so one cannot determine the factors that led to the inclusion of school mental health content.

4.5 PROGRAM E

4.5.1 To what extent do leading preparation programs in the U.S. prepare aspiring school leaders to address the mental health concerns of K-12 students?

Program E dwells in an urban area of the Midwest region of the United States. Out of over 25,000 students enrolled, 1045 students are in the graduate school of education. Sixty-three

percent are full-time students and instructed by 78 full-time faculty. Programs related to education administration and supervision comprised 6% of enrolled students.

A review of one document that represented Program E's Program Overview and Mission Statement resulted in no occurrences of "school mental health", "children's mental health", or "mental health" with no text evidence applicable to the SMH Dimensions. Furthermore, there were no occurrences of text units representative of the 14 SMH Topics.

The researcher reviewed 12 out of 12 syllabi for Program E. Six syllabi contained text units relative to school mental health. Twenty-seven units formed the basis for this analysis of SMH Dimension and SMH Topics. As shown in Table 33 and like Program D, Dimension 4 – Communication and Collaboration had the greatest prevalence. Not far behind was Dimension 1 – Services and Practice and Dimension 2 - Program Evaluation and Assessment both showing 29.6%.

Table 34. Program E: Text Units According to SMH Dimension

SMH Dimension	Units Identified	%
Dimension 4 – Communication and Collaboration	9	33.3
Dimension 1 – Services and Practice	8	29.6
Dimension 2 – Program Evaluation and Assessment	8	29.6
Dimension 5 – Themes and	2	7.4

Content		
Dimension 3 - Access	0	0.0

Note. $n = 27$

As shown in Table 35, the review of all 27 text units identified in Program E revealed 22 words that qualified for the 14 SMH Topics. Resembling prevalence rates in the two other programs, both "community" and "special education/special populations/special needs" made up the most frequent occurrences at five each.

Table 35. Program E: Word Frequencies and Percentages According to 14 SMH Topics

SMH Topic	*f*	%
Community	5	22.7
Special education/special populations/special needs/disabilities	5	22.7
At risk/high risk	2	9.0
Family/parent	2	9.0
Safety	2	9.0
School climate	2	9.0
Child Abuse	1	4.5
Discipline	1	4.5

School culture	1	4.5
Sexuality	1	4.5
Sexual violence/sexting	0	0.0
Bully/cyber bully/victimization	0	0.0
Collaborate	0	0.0
Communicate/communication	0	0.0

4.5.2 If school mental health is included in principal preparation programs, how is the aspiring school leader exposed to school mental health content?

Program E contained evidence of text units in many areas of syllabi context as seen in Table 36.

Table 36. Program E: Text Units According to Syllabi Context

Syllabi Context	*f*	%
Topic	6	22.2
Examples of data for school improvement	5	18.5
Course expectations	5	18.5
Required reading	4	14.8
Reading	3	11.1
Supplemental reading	2	7.4
Course scope	1	3.7

Special seminar	1	3.7

Note. $n = 27$

4.5.3 How do faculty members characterize the factors that have led to the inclusion of school mental health content in their principal preparation programs?

This program was the only program in the study for which a phone interview was successfully completed. Prior to the interview, the researcher sent a copy of the text unit evidence by SMH dimension and by SMH topic to the participant for review. Before questioning, the respondent shared that he had been director of the program for five years and was not sure if he could answer the questions about school mental health. He also explained that the master's level course requirements are the same as the principal licensure requirements.

When asked, "how long has the content related to SMH been in the program," the participant shared that the evaluation and assessment of Program E is "based on the ISLLC standards" and therefore outcomes and goals of courses are driven by the same set of standards. As for including content specific to school mental health the participant was not sure of any details.

The second question the interviewer asked was, "who or what influenced the decision(s) to include this content in the program?" The participant was not able to answer this.

Finally, the interviewer asked, "Do you plan to expand or contract this content in the future? If so, why?" At this juncture, the participant stated that there is one specific course in

the program that addresses “demographics”. This course conveys content such as principals and special education, race, gender, student improvement team, and children at risk. Just this summer the program expanded the content of that course and it is considering it for doctoral level students. There were no plans for further extensions or additions of content related to school mental health.

Additionally, the participant shared that the field experience required of students is at least a full calendar year and requires 240 logged and analyzed activities within seven or eight areas. This allows students to simultaneously experience and connect course work and fieldwork. The program director shared that there are expectations of students’ fieldwork related to school mental health. The researcher confirmed that the syllabus outlining fieldwork had five text units identified; all coded as “course expectations” and as SMH Dimension 1 – Services and Practice. One example was, “…to identify[ing] aspects of the principal’s role and behavior that contribute in helpful ways to maximizing the effective an efficient use of the support services. Attention also should be given to identifying administrative behaviors that should be avoided if an effective climate of cooperation and mutual support is maintained.”

In review of Program E, there were 27 text units identified in 6 out of 12 syllabi. This program shows evidence of multiple text units, which overtly address the role of the principal in support services. This was unique to Program E.

5.0 DISCUSSION

Schools are centerpieces of the school mental health movement. Given the increasing prevalence of children's mental health disorders and the barriers to learning associated with those disorders, we would expect school leaders to possess basic competencies in identification of, knowing about, planning for, and serving children with mental health needs.

To review, three reports address the high prevalence of children's mental health disorders, the correlation between mental health and academic achievement and why schools are viewed as an epicenter for intervention. The Centers for Disease Control and Prevention (CDC) reported in 2006 that approximately 8.3 million children (14.5%) aged 4–17 years had parents who had communicated during the previous year with a health care provider or school staff member about their child's emotional or behavioral difficulties (Simpson, Cohen, Pastor, & Reuben, 2008). Furthermore, multiple studies support a strong relationship between mental health disorders and poor academic achievement (Binser & Försterling, 2002; Doyle et al., 2004; Fergusson & Woodward, 2002) (Binser & Försterling, 2002; Doyle et al., 2004; Ferguson & Woodward, 2002; Rothan et al., 2009). Finally, the national bi-annual report, Risk Behaviors Commonly Associated with Youth Mental Health Disorders, indicates that schools have multiple

opportunities to identify those youth who may develop mental health disorders, including those at risk for suicide and homicide (CDC, 2012).

In spite of empirical evidence regarding the link between student achievement and mental health disorders in children, there is evidence that school leaders' lack of information and training continues to be a barrier to the provision of SMH services (see section 2.3.4.1, Barriers to School Mental Health). Despite highly visible reports, compelling data, and calls for more training, the principal preparation programs reviewed in this study do not appear to address mental health disorders as major barriers to academic achievement, arguably the primary mission of school leaders.

Since this study focuses on the fields of school leadership and school mental health, this discussion first acknowledges the common agenda held by both disciplines – academic achievement. This section then contemplates collaborative efforts and recommendations for both fields from the national to local level.

Motivating both fields of education administration and SMH is the common goal of increasing academic achievement. Education administration experts strongly endorse research proving the positive effects instructional leadership has on student achievement (Miller, Goddard, Goddard, Larsen & Jacob, 2010; Marks & Printy, 2003). Likewise, SMH leaders recount research that unidentified and unaddressed mental health disorders in children lead to poor academic outcomes (Ding, Lehrer, Rosenquist, &Audrain-McGovern, 2009; Binser & Forsterling, 2002; Lane, Baron-Arwood, Nelson & Wehby, 2008). This common goal is a unifying presence between these two disciplines.

In spite of this common agenda, these two fields continue to exist in isolation of each other. This is substantiated here by 1) the review of literature, which reveals very little crossover, 2) the review of standards and competencies that uncovers only minimal and indirect references to both fields and, 3) the review of over 90 documents from principal preparation programs that shows the text "school mental health" to be nonexistent. Let us consider the current state of collaboration between these two fields, assessed through the seven phases of collaboration featured in Table 5 of section 2.3.2 of this document. In order to plot an exact location of collaborative efforts[21] between School Leadership and SMH, one must first reflect on a few examples in the field.

5.1 COLLABORATION AT THE NATIONAL LEVEL

Nationally, these two fields seem to be, given the continuum of seven stages, at stage two, Communication – there may be sharing about initiatives, but nothing concrete or even child specific. Exchange of knowledge relates only to each other's capabilities. At this stage of collaboration, education administration and SMH seem to be very separate fields. There is no evidence of meaningful integration at the national level, as indicated by policies and competencies written in isolation of one another.

[21] These seven stages encapsulate the models of Peterson (1991), Hogue (1993), Gajda (2003), and Frey et al. (2002). Coexistence, Communication, Cooperation, Coordination, Coalition, True Collaboration, Coadunation.

This conclusion relies on the review of the literature that reveals only a few instances of collaboration. For instance, it appears that SMH leaders when assembling SMH workforce competencies did so without the voice of school leadership. Nor did the literature review reveal a substantive presence of the major school leadership organizations in the published literature on SMH. Moreover, national educational leadership consortia such as the ISLLC and the ELCC do not even tangentially mention SMH in their policy or performance standards, nor do they reference SMH authors or resources.

Consider three examples as close encounters offering promise for increased national collaborations. In 2006, ASCD, a professional educational association formerly referred to as the Association for Supervision and Curriculum Development, developed *The Learning Compact Redefined: A Call to Action.* This includes five student-specific goals and calls for stronger partnerships between public health systems and education. This effort has led to the development of The Whole Child Approach complete with a supporting website that even features a podcast, *What Does it Take for Children to be Mentally Healthy?* Interestingly, among the 60 plus Whole Child Partners, the Center for School Mental Health is not listed, but the Intercahms Society[22] is. This collaborative effort may be an example of Coordination, stage 4 of the collaboration continuum. Coordination is when both parties work together to achieve common outcomes.

A second example of increased collaborative encounters between these two fields is a webinar recently hosted by UCEA titled, *School Crisis Prevention and Intervention: Preparing*

[22] International Alliance for Childhood and Adolescent Mental Health Society

School Leaders for What Lies Ahead (Kerr, 2012). This talk was one in a series of webinars highlighting research and practice that encourages high quality preparation of school leaders. We could consider this as an example of stage 3 collaboration - Cooperation. Cooperation is when both parties share information to focus on cross training. This webinar is a sign of collaborative movement between educational administration and SMH as currently educational administration does not list such standards for their aspiring school leaders.

One can find a final example of improved collaborative efforts in the Mental Health Education Integration Consortium (MHEDIC). This national organization meets biannually to review and consider policy affecting children's mental health in education. Encouragingly, MHEDIC recently invited a few education administrators to be contributing members.

One example of a *missed opportunity* to collaborate is within a report called, *The School Turnaround Field Guide* published by the Foundation Strategy Group, Carnegie Corporation of New York, and The Wallace Foundation (2010). The authors base this field guide on interviews of "turn around experts" as well as on research of such schools and discuss sustainability, strategies, and policies related to turnaround schools. The purpose of the guide is to advise school leaders. It is heartening that one section of this guide addresses "Supporting Partners." It is within this final set that the authors share, "Integrated service providers help schools identify and address the cultural and mental health factors that drive chronically poor performance" (p. 30). Although this guide does illustrate how a school might address mental health needs of students in extreme distress, it falls short by not sharing with its readers the vast resources of the SMH movement. This is not surprising, given that the document was authored almost

exclusively by those in the educational administration field. Recommendations for National Level Action

Without an increase in representation at the national level, then content of SMH may never permeate leadership preparation programs and vice versa. This discussion offers several recommendations at the national level in order to move these two fields further along the continuum of collaboration. First, major national organizations in both Educational Administration organizations (UCEA, NPBEA, CCSSO, ISLLC) and SMH organizations (MHEDIC, CSMH) mighty consider reports and position papers published in strategically selected journals. Additionally, it might be helpful for these organizations to be more inclusive of each other when preparing conference themes. These themes could feature the coupling of educational administration and SMH. Conference planners could also initiate round table discussions with both leaders in educational administration and SMH present. Agendas could derive from documents such as the ISLLC Standards, National Guidelines, key papers outlining barriers, and current research topics in both fields. Additionally, it might be useful to frame initial discussions at the national level by examining cases in the field. These cases might feature district or building level leaders who have prepared a context conducive to SMH, thereby addressing mental health needs of all students and increasing student achievement.

Beyond considering collaboration at the national level, one must also ponder the current collaborative picture of these two fields at the state and local levels. In order to achieve this, following is a depiction of school leadership and SMH that moves through four phases of implementing a SMH program – Planning, Program Development, Implementation, and

Evaluation. The discussion addresses expectations of school leaders in each phase and references the SMH Dimensions data.

5.2 RECOMMENDATIONS FOR NATIONAL LEVEL ACTION

Without an increase in representation at the national level, then content of SMH may never permeate leadership preparation programs and vice versa. This discussion offers several recommendations at the national level in order to move these two fields further along the continuum of collaboration. First, major national organizations in both Educational Administration organizations (UCEA, NPBEA, CCSSO, ISLLC) and SMH organizations (MHEDIC, CSMH, Council for Children with Behavior Disorders, NASP, NASSW) may consider joint position papers published in strategically selected journals. Additionally, it might be helpful for these organizations to be more inclusive of each other when preparing conference themes. These themes could feature the coupling of Educational Administration and SMH. They could also initiate round table discussions with both leaders in Educational Administration and SMH present at the table. Agendas could derive from documents such as the ISLLC Standards, National Guidelines, key papers outlining barriers, and current research topics in both fields. Additionally, it might be useful to frame initial discussions at the national level by examining cases in the field. These cases may feature district or building level leaders who have prepared a context conducive to SMH thereby addressing mental health needs of all students and increasing student achievement.

Beyond considering collaboration at the national level, we must also ponder the current collaborative picture of these two fields at the state and local levels. In order to achieve this, following is a depiction of Educational Leadership and SMH that moves through four phases of implementing a SMH program – Planning, Program Development, Implementation, and Evaluation. The discussion addresses expectations of school leaders in each phase and includes aggregate data representing the SMH Dimensions data.

5.3 COLLABORATION AT THE STATE AND LOCAL LEVELS

State and local level collaborative efforts between these two fields means examining not only policy, but also practice and performance. This section summarizes the content and supporting pedagogy identified---or missing--- in the five programs. This section frames the findings around four phases of developing SMH capacity. These phases are planning, program development, implementation, and program evaluation. To begin, a building principal should plan and organize a school environment to increase school personnel's awareness of, and ability to serve (often in partnership), students with mental health disorders.

5.3.1 Planning for SMH

Planning for SMH requires a rudimentary understanding of vocabulary of mental health disorders, without which educators encounter barriers in seeking services or effecting

partnerships with other disciplines. To review, this paper began with a presentation of the definitional issues and specialized vocabulary required to advocate and serve children with mental health needs.

Secondly, one would expect leaders to map internal and external resources in order to understand present capacity. Examples of internal resources may include counseling services, crisis planning, bully prevention, drug and alcohol prevention, and other student assistance programs. External resources would include community-based services such as psychiatrists, psychologists, therapists, and community crisis response systems. A formative assessment of current resources and needs allows for data-driven program development and efficient, coordination of services, especially important in a difficult economy. This would mean identifying available interventions along a continuum of primary, secondary and tertiary tiers of intervention as well as completing utilizing and a formative assessment such as the School Health Index (CDC, 2012) or the *School Mental Health Quality Assessment Questionnaire* (SMHQAQ, 2010).

Thirdly, school leaders must also marshal personnel to determine the current state of students' behavioral and emotional well-being. Examples of this assessment include examining data on discipline, bullying, absenteeism, truancy, school nurse visits, and numbers of students eligible for emotional and behavioral support through special education.

In summary, it appears that aspiring school leaders may graduate without even a working vocabulary and understanding of definitions in the field of SMH. As noted in the literature review, a highly specialized vocabulary, with disparate definitions of mental health disorder, characterizes the field of SMH. Absent this vocabulary, school leaders may find conversations,

collaborations, and partnerships especially challenging. Exacerbating this deficit (aside from numerous readings on bullying) is the fact that students do not appear to be reading any of the SMH literature, unless in elective courses. It follows, then, that these aspiring school leaders may not be developing a familiarity with the language, models, or concepts associated with SMH.

5.3.2 Program Development

The second phase when building a SMH program is Program Development. Given their leadership positions cited by the architects of the SMH movement, graduates of the leading programs would be expected to have some competency in cultivating school referral services and SMH programming. One would expect a principal to have a general understanding of SMH services and practices (Dimension 1), a fundamental awareness of access to care and funding (Dimension 3), and the ability to communicate and collaborate with internal and external resources, as reflected in Dimension 4 Communication and Collaboration. This implies facilitating and participating in meetings about stakeholder involvement and feedback. These meetings require interdisciplinary collaboration and communication as well as community coordination and communication. Yet, the program with the highest prevalence of text units related to SMH (Program A) revealed *no* units in Dimension 4 – Communication and Collaboration. Absent these skills, principals would undoubtedly join those whom the SMH literature has characterized as barriers to the provision of essential SMH services (Weist & Paternite, 2006).

Pupils with unmet mental health needs create a financial strain for a district and community, as highlighted in the literature (see section 2.2.4). Expectations of school leaders may be to work with mental health professionals to not only locate underutilized funds but also advocate for appropriate funding to transform the current system of "over-burdened school-employed mental health professionals" (Weist & Paternite, 2006, p. 177). Stakeholders may not expect school leaders to independently secure funding, but school leaders are certainly in a key position to promote sustainable programming of SMH. It follows, then, that principals should have the competency to access and manage monies and services that meet the needs of students. SMH Dimension 3 – Access revealed *no text units* reflecting this expectation. Armed with no training about SMH funding and services and only a minimal grasp of the importance of unmet mental health needs, a school leader may have no reason to seek funding for prevention, early intervention or intensive services.

5.3.3 Implementation and Evaluation

The third and fourth phases to consider in building SMH capacity are Implementation and Evaluation. Stakeholders expect principals to oversee implementation of SMH procedures and then report progress by arranging for ongoing assessments, often coordinated with other professionals such as social workers, special educators, school health and mental health specialists, and those in law enforcement. In addition to communication and collaboration with other systems of care professionals, leaders should have some working knowledge about how to coordinate and integrating systems in order to avoid fragmentation or duplication of services.

Moreover, leaders need to know how to access information to make sound decisions about best practices in SMH, including some knowledge of practices to avoid (e.g., practices that promote suicide contagion or other high-risk behaviors). An awareness of systems frameworks, delineation of roles, recognition of effective, evidence-based SMH practices, and knowledge of assessment tools and strategies are essential to both Implementation and Evaluation.

While one could argue that all five Dimensions of SMH support Implementation and Evaluation, the text evidence in all five programs were vague or at best indirectly related to SMH. For instance, a text unit that qualified for Dimension 2 – Program Evaluation and Assessment was found in a rubric as "assess school culture using multiple methods and implement context-appropriate assess school culture using multiple methods and implement context-appropriate strategies that capitalize on students with disabilities in the school community to improve school programs" (Educational Leaders Constituents Council, 2008). This text unit is actually one of the ELCC criteria supporting the element, Learner Growth Standard 2 – School Culture and Instructional Program. One wonders, then, if this text unit reflects any concepts linked to SMH.

5.4 RECOMMENDATIONS FOR STATE AND LOCAL LEVEL ACTION

One recommendation is to consider the content of school leadership preparation programs. Higher education programs preparing principals should not have as their goal to graduate school

leaders who are also SMH experts. But at a minimum, programs should consider addressing these competencies: 1) introduction to a definition of SMH[23], 2) vocabulary including key mental health terms, 3) featured case studies demonstrating how to build SMH capacity, 4) introduction to data bases with statistics reflecting children's mental health disorders (CDC, YRBS), 5) introduction to credible resources highlighting evidence-based and best practices (Health, Mental Health and Safety Guidelines for Schools), 6) introduction to tools that will encourage formative evaluation of schools (SHI, SMHQAQ). Finally, pedagogy should counter the negative stigma associated with the words "mental health."

5.5 LIMITATIONS AND IMPLICATIONS FOR FUTURE RESEARCH

This section considers several limitations to note regarding this exploratory study. This study only reviewed five programs designed to prepare principals for school leadership roles. Therefore, the researcher cautions about general application of findings. A more robust study would feature a greater number of reviewed programs.

A second limitation was restricted access to documents. While understandable, this does limit what programs can garner from others across the country. It would be advantageous if

[23] Intercahms working definition of School Mental Health: "Promoting mental health through schools is undertaken by utilizing a 'whole school' approach that includes development and support of a continuum of mental health promotion, intervention, and treatment options, as well as active adoption of enabling policies and practices leading toward a healthy psychosocial school environment, and on-site services provided by allied professionals. Further, skills for social emotional learning and the involvement of parents and the broader community are critical components of this approach" (Intercahms, 2012).

programs were more willing to share. Syllabi were not available for review on program websites for any course across the five selected programs. The researcher excluded several programs of interest because the program would not share syllabi with non-enrolled students. Furthermore, other programs simply explained that they were not interested in participating. In order to elicit authentic and comparative data in the future, increased access to these documents would be helpful.

Along the lines of accessing documents was difficulty gaining a remote understanding of a program as a whole. Departments and programs in higher education are continually changing. It was difficult to ascertain if the researcher had *current* documents. For example, one Program listed required courses for certification on the website, but when the researcher reviewed syllabi sent for review, the numbers and titles of courses had changed, making it difficult to determine if every course required for certification was obtained.

Outdated website information also was found to limit the data. Discerning timelines, number of cohorts, and required courses was complicated by website information that conflicted with actual documents outlining requirements. For one program, the researcher retrieved the names of instructors from the program website that featured course titles and instructors. However, when emailing individual instructors, it became clear that the website was not updated as some of the instructors contacted were no longer employed in that program. As a result, the researcher sequentially excluded such programs from the study.

When examining text for word frequencies, the data allowed for lemmatization but not for synonyms or phrases connoting like meanings. For example, the SMH category “sexuality” reflects only words with similar root. However, an example of additional qualifying text that

was not included was, “adolescent beliefs about gay and lesbian peers” and “masculine female adolescents.” This resulted in perhaps an underreporting of word occurrences related to SMH. Future studies might consider using different search parameters.

The researcher found it difficult to isolate courses exclusive to principal licensure. It difficult to sort courses required for licensure versus additional courses required for the completion of a masters’ level program. While some programs design the licensure as the masters degree, others may have had two sets of documents for licensure; one set for students only obtaining licensure and another set for students in a combined program.

Another limitation of this document analysis were the dates on several syllabi. Year dates ranged from 2008 – 2012. Two of the five programs reviewed had syllabi from a variety of years. It would be ideal to consider a program holistically with documents from the same school year.

This study took place in part during the summer months when faculty members are more likely unavailable. Therefore, the researcher was only able to secure one interview. The interview data were critical to both qualitative and quantitative data collection. Future research should consider faculty work calendars and plan accordingly. Another approach would be to gather data at a conference attended by relevant faculty, such as the University Council of Education Administration.

Finally, when considering text evidence coded by syllabi context, the researcher found it difficult to determine instructor expectations because of the abbreviated nature of some syllabi. Future research may want to focus exclusively on pedagogical decisions for teaching school mental health related topics. There is a preponderance of strong case material and textbooks

written for school leaders. These materials address SMH topics and can be adapted and utilized for the higher education setting. It might also be useful to highlight presentations at major national meetings of institutions on how instructors in higher education could use this content at major national meetings of institutions that prepare school leaders.

6.0 CONCLUSION

In summary, this study, albeit it limited in scope, may have uncovered a serious deficit in the preparation of future principals. Given the prevalence of mental health disorders and the significant burden they place on children, families and schools, one would expect to see content and pedagogy related to this urgent national concern. Yet, licensure and certification standards are nearly silent on this topic (ISLLC, 2008). It is not surprising, therefore, that the data reveal little or no emphasis on SMH as a priority for school *leaders*. Moreover, it would appear that graduates of these programs, cited as among the best in the nation, would not even have a fundamental awareness or vocabulary to participate in *non-leadership* roles in discussions about children's mental health. Further compounding the training deficit is the absence of any mention of readily available resources that could empower curious new principals to explore these topics on their own. It is no wonder that two of the leading architects of the SMH movement were forced to conclude that poor understanding of mental/behavioral health of children by school leaders only perpetuates the perception of mental health as an added service – an issue only addressed when a student is in serious distress (Weist & Paternite, 2006).

We know that one in every five school-aged children has a mental health disorder likely to impair learning (Benner et al., 2004). Taken another way, a principal overseeing the

education of 500 children has in his charge 100 pupils whose mental health needs may not only impede their learning, but also interfere with the learning of others. Compounding the problem further, children with mental health needs often have parents whose own needs make it difficult for them to engage in the schooling process (McMorrow & Howell, 2010).

One possible reason for the missing SMH content and pedagogy may be the lack of clarity with respect to competencies and performance standards for school leaders. Absent a national repository of certification requirements for principals, it is difficult to assess how many, if any, states require this content. Nevertheless, were the content required in the states where the five programs are based, one would expect to see evidence of the competencies reflected in their curricula and pedagogy.

Were the SMH movement a *new* initiative, one could understand how its history and its place in the lives of school leaders might be overlooked. However, the SMH movement has been rapidly and publicly advancing for over three decades. For decades and usually at no cost, the knowledge, models, and tools for equipping new school leaders for this formidable task have been readily available. It is surprising, therefore, that addressing children's mental health needs does not appear to be even a minor focus for some principal preparation programs or for the national bodies that guide curriculum in educational leadership.

In conclusion, this inaugural examination of some of the nation's leading principal preparation programs presents a discouraging picture. Unless and until principal preparation programs take seriously the lessons of their colleagues in the national SMH movement, hundreds of thousands of children face a future handicapped not only by their emotional and behavioral struggles but also impeded throughout their lives by their inability to succeed in academic

endeavors. Our future generations rely on their K-12 school leaders not only to ensure their academic and vocational preparation but to recognize and value their emotional and behavioral well-being as fundamental for their success. To do less is to further not only the burden on these youth but also on the generations that must provide for them.

APPENDIX A

ELCC BUILDING-LEVEL STANDARDS-2011

2011 ELCC Building Level Standards

Standard 1.0: A building-level education leader applies knowledge that promotes the success of every student by collaboratively facilitating the development, articulation, implementation, and stewardship of a shared school vision of learning through the collection and use of data to identify school goals, assess organizational effectiveness, and implement school plans to achieve school goals; promotion of continual and sustainable school improvement; and evaluation of school progress and revision of school plans supported by school-based stakeholders.
1.1 Candidates understand and can collaboratively develop, articulate, implement, and steward a shared vision of learning for a school.
1.2 Candidates understand and can collect and use data to identify school goals, assess organizational effectiveness, and implement plans to achieve school goals.
1.3 Candidates understand and can promote continual and sustainable school improvement.
1.4 Candidates understand and can evaluate school progress and revise school plans supported by school stakeholders.

Standard 2.0: A building-level education leader applies knowledge that promotes the success of every student by sustaining a school culture and instructional program conducive to student learning through collaboration, trust, and a personalized learning environment with high expectations for students; creating and evaluating a comprehensive, rigorous and coherent curricular and instructional school program; developing and supervising the instructional and leadership capacity of school staff; and promoting the most effective and appropriate technologies to support teaching and learning within a school environment.
2.1 Candidates understand and can sustain a school culture and instructional program conducive to student learning through collaboration, trust, and a personalized learning environment with high expectations for students.

2.2 Candidates understand and can create and evaluate a comprehensive, rigorous, and coherent curricular and instructional school program.
2.3 Candidates understand and can develop and supervise the instructional and leadership capacity of school staff.
2.4 Candidates understand and can promote the most effective and appropriate technologies to support teaching and learning in a school environment.

Standard 3.0: A building-level education leader applies knowledge that promotes the success of every student by ensuring the management of the school organization, operation, and resources through monitoring and evaluating the school management and operational systems; efficiently using human, fiscal, and technological resources in a school environment; promoting and protecting the welfare and safety of school students and staff; developing school capacity for distributed leadership; and ensuring that teacher and organizational time is focused to support high-quality instruction and student learning.
3.1 Candidates understand and can monitor and evaluate school management and operational systems.
3.2 Candidates understand and can efficiently use human, fiscal, and technological resources to manage school operations.
3.3 Candidates understand and can promote school-based policies and procedures that protect the welfare and safety of students and staff within the school.
3.4 Candidates understand and can develop school capacity for distributed leadership.
3.5 Candidates understand and can ensure teacher and organizational time focuses on supporting high-quality school instruction and student learning.

Standard 4.0: A building-level education leader applies knowledge that promotes the success of every student by collaborating with faculty and community members, responding to diverse community interests and needs, and mobilizing community resources on behalf of the school by collecting and analyzing information pertinent to improvement of the school's educational environment; promoting an understanding, appreciation, and use of the diverse cultural, social, and intellectual resources within the school community; building and sustaining positive school relationships with families and caregivers; and cultivating productive school relationships with community partners.
4.1 Candidates understand and can collaborate with faculty and community members by collecting and analyzing information pertinent to the improvement of the school's educational environment.
4.2 Candidates understand and can mobilize community resources by promoting an understanding, appreciation, and use of diverse cultural, social, and intellectual resources within the school community.
4.3 Candidates understand and can respond to community interests and needs by building and sustaining positive school relationships with families and caregivers.
4.4 Candidates understand and can respond to community interests and needs by building and sustaining productive school relationships with community partners.

Standard 5.0: A building-level education leader applies knowledge that promotes the success of every student by acting with integrity, fairness, and in an ethical manner to ensure a school system of accountability for every student's academic and social success by modeling school principles of self-awareness, reflective practice, transparency, and ethical behavior as related to their roles within the school; safeguarding the values of democracy, equity, and diversity within the school; evaluating the potential moral and legal consequences of decision making in the school; and promoting social justice within the school to ensure that individual student needs inform all aspects of schooling.
5.1 Candidates understand and can act with integrity and fairness to ensure a school system of accountability for every student's academic and social success.
5.2 Candidates understand and can model principles of self-awareness, reflective practice, transparency, and ethical behavior as related to their roles within the school.
5.3 Candidates understand and can safeguard the values of democracy, equity, and diversity within the school.
5.4 Candidates understand and can evaluate the potential moral and legal consequences of decision making in the school.
5.5 Candidates understand and can promote social justice within the school to ensure that individual student needs inform all aspects of schooling.

Standard 6.0: A building-level education leader applies knowledge that promotes the success of every student by understanding, responding to, and influencing the larger political, social, economic, legal, and cultural context through advocating for school students, families, and caregivers; acting to influence local, district, state, and national decisions affecting student learning in a school environment; and anticipating and assessing emerging trends and initiatives in order to adapt school-based leadership strategies.
6.1 Candidates understand and can advocate for school students, families, and caregivers.
6.2 Candidates understand and can act to influence local, district, state, and national decisions affecting student learning in a school environment.
6.3 Candidates understand and can anticipate and assess emerging trends and initiatives in order to adapt school-based leadership strategies.

Standard 7.0: A building-level education leader applies knowledge that promotes the success of every student through a substantial and sustained educational leadership internship experience that has school-based field experiences and clinical internship practice within a school setting and is monitored by a qualified, on-site mentor.
7.1 Substantial Field and Clinical Internship Experience: The program provides significant field experiences and clinical internship practice for candidates within a school environment to synthesize and apply the content knowledge and develop professional skills identified in the other Educational Leadership Building-Level Program Standards through authentic, school-based leadership experiences.
7.2 Sustained Internship Experience: Candidates are provided a six-month, concentrated (9–12 hours per week) internship that includes field experiences within a school-based environment.

7.3 Qualified On-Site Mentor: An on-site school mentor who has demonstrated experience as an educational leader within a school and is selected collaboratively by the intern and program faculty with training by the supervising institution.

APPENDIX B

ELCC DISTRICT-LEVEL STANDARDS 2011

2011 ELCC District Level Standards

Standard 1.0: A district-level education leader applies knowledge that promotes the success of every student by facilitating the development, articulation, implementation, and stewardship of a shared district vision of learning through the collection and use of data to identify district goals, assess organizational effectiveness, and implement district plans to achieve district goals; promotion of continual and sustainable district improvement; and evaluation of district progress and revision of district plans supported by district stakeholders.
1.1 Candidates understand and can collaboratively develop, articulate, implement, and steward a shared district vision of learning for a school district.
1.2 Candidates understand and can collect and use data to identify district goals, assess organizational effectiveness, and implement district plans to achieve district goals.
1.3 Candidates understand and can promote continual and sustainable district improvement.
1.4 Candidates understand and can evaluate district progress and revise district plans supported by district stakeholders.

Standard 2.0: A district-level education leader applies knowledge that promotes the success of every student by sustaining a district culture conducive to collaboration, trust, and a personalized learning environment with high expectations for students; creating and evaluating a comprehensive, rigorous, and coherent curricular and instructional district program; developing and supervising the instructional and leadership capacity across the district; and promoting the most effective and appropriate technologies to support teaching and learning within the district.
2.1 Candidates understand and can advocate, nurture, and sustain a district culture and instructional program conducive to student learning through collaboration, trust, and a personalized learning environment with high expectations for students.
2.2 Candidates understand and can create and evaluate a comprehensive, rigorous, and coherent curricular and instructional district program.

2.3 Candidates understand and can develop and supervise the instructional and leadership capacity across the district.
2.4 Candidates understand and can promote the most effective and appropriate district technologies to support teaching and learning within the district.

Standard 3.0: A district-level education leader applies knowledge that promotes the success of every student by ensuring the management of the district's organization, operation, and resources through monitoring and evaluating district management and operational systems; efficiently using human, fiscal, and technological resources within the district; promoting district-level policies and procedures that protect the welfare and safety of students and staff across the district; developing district capacity for distributed leadership; and ensuring that district time focuses on high-quality instruction and student learning.

3.1 Candidates understand and can monitor and evaluate district management and operational systems.
3.2 Candidates understand and can efficiently use human, fiscal, and technological resources within the district.
3.3 Candidates understand and can promote district-level policies and procedures that protect the welfare and safety of students and staff across the district.
3.4 Candidates understand and can develop district capacity for distributed leadership.
3.5 Candidates understand and can ensure that district time focuses on supporting high-quality school instruction and student learning.

Standard 4.0: A district-level education leader applies knowledge that promotes the success of every student by collaborating with faculty and community members, responding to diverse community interests and needs, and mobilizing community resources for the district by collecting and analyzing information pertinent to improvement of the district's educational environment; promoting an understanding, appreciation, and use of the community's diverse cultural, social, and intellectual resources throughout the district; building and sustaining positive district relationships with families and caregivers; and cultivating productive district relationships with community partners.
4.1 Candidates understand and can collaborate with faculty and community members by collecting and analyzing information pertinent to the improvement of the district's educational environment.
4.2 Candidates understand and can mobilize community resources by promoting understanding, appreciation, and use of the community's diverse cultural, social, and intellectual resources throughout the district.
4.3 Candidates understand and can respond to community interests and needs by building and sustaining positive district relationships with families and caregivers.
4.4 Candidates understand and can respond to community interests and needs by building and sustaining productive district relationships with community partners.

Standard 5.0: A district-level education leader applies knowledge that promotes the success of every student by acting with integrity, fairness, and in an ethical manner to ensure a district system of accountability for every student's academic and social success by modeling district principles of self-awareness, reflective practice, transparency, and ethical behavior as related to their roles within the district; safeguarding the values of democracy, equity, and diversity within the district; evaluating the potential moral and legal consequences of decision making in the district; and promoting social justice within the district to ensure individual student needs inform all aspects of schooling.
5.1 Candidates understand and can act with integrity and fairness to ensure a district system of accountability for every student's academic and social success.
5.2 Candidates understand and can model principles of self-awareness, reflective practice, transparency, and ethical behavior as related to their roles within the district.

5.3 Candidates understand and can safeguard the values of democracy, equity, and diversity within the district.
5.4 Candidates understand and can evaluate the potential moral and legal consequences of decision making in the district.
5.5 Candidates understand and can promote social justice within the district to ensure individual student needs inform all aspects of schooling.

Standard 6.0: A district-level education leader applies knowledge that promotes the success of every student by understanding, responding to, and influencing the larger political, social, economic, legal, and cultural context within the district through advocating for district students, families, and caregivers; acting to influence local, district, state, and national decisions affecting student learning; and anticipating and assessing emerging trends and initiatives in order to adapt district-level leadership strategies.
6.1 Candidates understand and can advocate for district students, families, and caregivers.
6.2 Candidates understand and can act to influence local, district, state, and national decisions affecting student learning in a district environment.
6.3 Candidates understand and can anticipate and assess emerging trends and initiatives in order to adapt district-level leadership strategies.

Standard 7.0: A district-level education leader applies knowledge that promotes the success of every student in a substantial and sustained educational leadership internship experience that has district-based field experiences and clinical practice within a district setting and is monitored by a qualified, on-site mentor.
7.1 Substantial Experience: The program provides significant field experiences and clinical internship practice for candidates within a district environment to synthesize and apply the content knowledge and develop professional skills identified in the other Educational Leadership District-Level Program Standards through authentic, district-based leadership experiences.
7.2 Sustained Experience: Candidates are provided a six-month concentrated (9–12 hours per week) internship that includes field experiences within a district environment.

7.3 Qualified On-site Mentor: An on-site district mentor who has demonstrated successful experience as an educational leader at the district level and is selected collaboratively by the intern and program faculty with training by the supervising institution.

APPENDIX C

SCHOOL MENTAL HEALTH QUALITY ASSESSMENT QUESTIONAIRRE (SMQAQ)

Center for School Mental Health

July 2010

SCHOOL TEAM VERSION

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Please answer each item that follows based on services provided by mental health staff in your school. This could include services provided by school-employed staff such as school counselors, psychologists, social workers, nurses and other pupil personnel, and collaborating mental health staff from the community. *Please select the number that best reflects the degree that the item is developed and/or implemented. Thank you*.

Principle 1: All youth and families are able to access appropriate care regardless of their ability to pay.	don't know	not at all in place	fully in place
ACCESS TO CARE			

1) When indicated, does your school mental health team provide case management assistance to students and families to assist them in obtaining health insurance or to facilitate enrollment in programs for which they are eligible?	0	1	2	3	4	5	6
FUNDING							
2) Is your school mental health team engaged in activities that may bring resources or financial support into the school mental health program?	0	1	2	3	4	5	6
Principle 2: Programs are implemented to address needs and strengthen assets for students, families, schools, and communities.	don't know	not at all in place					fully in place
NEEDS ASSESSMENT							
3) Has your school mental health team conducted assessments on common risk and stress factors faced by students (e.g., exposure to crime, violence, substance abuse)?	0	1	2	3	4	5	6
4) Has the school mental health team held meetings with students, parents, and teaching staff to ask them about their needs and to ask them for their recommendations for actions by school mental health staff?	0	1	2	3	4	5	6
ADDRESSING NEEDS AND STRENGTHS							
5) Does the school mental health team have services in place to help students contend with common risk and stress factors?	0	1	2	3	4	5	6
6) Does the school mental health team match provided services to the presenting needs and strengths of students/families after initial assessment?	0	1	2	3	4	5	6

Principle 3: Programs and services focus on reducing barriers to development and learning, are student and family friendly, and are based on evidence of positive impact.	don't know	not at all in place					fully in place
EVIDENCE-BASED PRACTICE: **SCREENING, ASSESSMENT, AND INTERVENTION**							
7) Does your school mental health team receive ongoing training and supervision on effective diagnosis, treatment planning and implementation, and subsequent clinical decision-making?	0	1	2	3	4	5	6
8) Does your school mental health team conduct screening and follow-up assessments to assist in the identification and appropriate diagnosis of mental health problems?	0	1	2	3	4	5	6
9) Does your school mental health team continually assess whether ongoing services provided to students are appropriate and helping to address presenting problems?	0	1	2	3	4	5	6
10) Is there a clear and effective protocol to assist the school mental health team in their clinical decision making and care for more serious situations (e.g., abuse and neglect reports, self-reporting of suicidal/homicidal ideation)?	0	1	2	3	4	5	6

11) Is your school mental health team actively using the evidence-base (practices and programs) of what works in child and adolescent mental health to guide your preventive and clinical interventions?	0	1	2	3	4	5	6
Principle 4: Students, families, teachers and other important groups are actively involved in the program's development, oversight, evaluation, and continuous improvement.	don't know	not at all in place					fully in place
STAKEHOLDER INVOLVEMENT AND FEEDBACK							
12) Has an advisory board (including youth, families, administrators, educators, school health staff, community leaders) been developed for the school mental health programs?	0	1	2	3	4	5	6
13) Does the school mental health team collaborate closely with school administrators and offer numerous opportunities for recommendations, feedback, and involvement in program development and implementation?	0	1	2	3	4	5	6
14) Does the school mental health team participate in methods or activities (e.g., meetings, focus groups, surveys) to obtain feedback on an ongoing basis from key stakeholders on how the program is functioning and how it can be improved?	0	1	2	3	4	5	6
15) Does the school mental health team engage in efforts to ensure that stakeholder ideas and recommendations are actually implemented in a timely manner?	0	1	2	3	4	5	6
16) Does the school mental health team provide training and educational activities for families, teachers and other stakeholder groups based on their recommendations and feedback?	0	1	2	3	4	5	6

Principle 5: Quality assessment and improvement activities continually guide and provide feedback to the program.	don't know	not at all in place					fully in place
QUALITY ASSESSMENT AND IMPROVEMENT							
17) Are your school mental health team's efforts and activities being guided by an active and effective quality assessment and improvement plan that other school mental health clinicians and stakeholders (school staff, families, community) are aware of?	0	1	2	3	4	5	6
18) Has the school mental health team been well trained in paperwork requirements for the school mental health program, and do their records clearly reflect delineated policies and procedures?	0	1	2	3	4	5	6
19) Is the school mental health team ensuring that families are meaningfully involved in treatment planning and ongoing therapy efforts?	0	1	2	3	4	5	6
20) Are peer review mechanisms in place to receive feedback from other mental health staff on the way the team handles cases and/or implements preventive and clinical interventions?	0	1	2	3	4	5	6
21) Does the school mental health team actively use an evaluation plan that provides measurable results to and helps to improve preventive and clinical intervention efforts?	0	1	2	3	4	5	6
22) Does the team share positive and negative findings from the evaluation of services with youth, families, school staff and other stakeholders?	0	1	2	3	4	5	6

Principle 7: Staff holds to high ethical standards, is committed to children, adolescents, and families, and displays an energetic, flexible, responsive and proactive style in delivering services.	don't know	not at all in place					fully in place

Principle 6: A continuum of care is provided, including school-wide mental health promotion, early intervention, and treatment.	don't know	not at all in place					fully in place
CONTINUUM OF CARE							
23) Does the school mental health team offer activities promoting school-wide mental health?	0	1	2	3	4	5	6
24) Is the school mental health team actively involved in developing and implementing training and educational activities for educators on the identification, referral, and behavior management of social/emotional/behavioral problems in students?	0	1	2	3	4	5	6
25) Does the school mental health team offer group, classroom, and school-wide prevention activities?	0	1	2	3	4	5	6
26) Does the school mental health team offer intensive treatment services to youth and families including individual, group, and family therapy?	0	1	2	3	4	5	6
27) Is the team able to continue to have mentoring relationships with students who no longer present serious problems?	0	1	2	3	4	5	6
REFERRAL PROCESS							
28) Are referral procedures being well utilized by educators, the school mental health staff, other mental health staff, health staff, administrators, parents and students?	0	1	2	3	4	5	6
29) Does the school mental health team promptly screen/assess all students who have been referred for services?	0	1	2	3	4	5	6

CLINICIAN TRAINING, SUPPORT, AND SERVICE DELIVERY							
30) Is the school mental health team sufficiently trained, supported, and supervised to handle the unique demands of school-based practice in an ethical and effective manner?	0	1	2	3	4	5	6
31) Are the services provided by the school mental health team characterized by a flexible, proactive approach that enables youth and families in need to be served as rapidly as possible?	0	1	2	3	4	5	6
Principle 8: Staff is respectful of, and competently addresses developmental, cultural, and personal differences among students, families and staff.	don't know	not at all in place					fully in place
COMPETENTLY ADDRESSING DEVELOPMENTAL, CULTURAL, AND PERSONAL DIFFERENCES							
32) Does the school mental health team receive regular training on effectively providing care for students and families who present diverse developmental, cultural, ethnic, and personal backgrounds?	0	1	2	3	4	5	6
33) Does the school mental health team's caseload reflect the diversity of the school population?	0	1	2	3	4	5	6
34) Does the school mental health team make efforts to ensure that school mental health programs and services are welcoming and respect the students and families served?	0	1	2	3	4	5	6
35) Are key stakeholders who provide ongoing guidance to your school mental health program diverse in terms of gender, race/ethnicity, and personal/cultural background?	0	1	2	3	4	5	6
Principle 9: Staff builds and maintains strong relationships with other mental health and health providers and educators in the school, and a theme of interdisciplinary collaboration characterizes all efforts.	don't know	not at all in place					fully in place
INTERDISCIPLINARY COLLABORATION AND COMMUNICATION							
36) Does the school mental health team help to coordinate mental health efforts in the school to ensure that youth who need services receive them, while avoiding service duplication?	0	1	2	3	4	5	6
37) Is the school mental health team using or helping to develop communication mechanisms to ensure that information is appropriately shared and that student and family confidentiality is protected?	0	1	2	3	4	5	6
38) Does the school mental health team actively collaborate with other professionals in your school (other health/mental health providers, educators, administrators)?	0	1	2	3	4	5	6
Principle 10: Mental health programs in the school are coordinated with related programs in other community settings.	don't know	not at all in place					fully in place
COMMUNITY COORDINATION							
39) Is the school mental health team knowledgeable about existing mental health and related resources for students in the school and community and is this information readily available in a directory that can be broadly shared within the school?	0	1	2	3	4	5	6
40) Is the school mental health team working closely with other community health and mental health providers and programs to improve cross-referrals, enhance linkages, and coordinate and expand resources?	0	1	2	3	4	5	6

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